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Programs for Juvenile Offenders

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MASTERING A SKILL. The greatly increased incidence in Europe of deformities among babies whose mothers had taken the drug thalidomide during pregnancy has accelerated interest in further research in prosthetics in relation to children. This 3-year-old, who was born before the appearance of thalidomide but whose impairments are similar to those produced by the drug, eventually will have a prosthesis for his left arm similar to the one which he is learning to use effectively for his right arm.

A member of the bar with a master's degree in social work from Western Reserve University, William H. Sheridan has been with the Children's Bureau since 1949 when he came as consultant on juvenile delinquency. When the Division of Juvenile Delinquency Service was created in 1954, he became Chief of its Technical Aid Branch, moving from there to his present post in 1960. Before coming to the Bureau, he was chief probation officer with the Juvenile Court in Cleveland.

Until recently part of the evaluation team at the center which they describe in this issue, Thomas Atkins (right) is now chief psychologist at the Philadelphia Child Guidance Clinic, and psychiatrist Ora Smith is director of the Oakbourne Hospital in West Chester, Pa., a residential treatment center for children. Dr. Rose is director of the Philadelphia Child Guidance Clinic.

This fall Jacqueline McCoy has returned to her alma mater, the George Warren Brown School of Social Work, Washington University, to work for her doctorate. Since her graduation from there 11 years ago, she has concentrated on foster family and adoptive home finding for the past 7 years with the City of St. Louis Department of Welfare.

Besides providing the psychiatric consultation at the Tyler-Smith County Health Department, as described here, Loyce Buie (right) practices psychiatry privately in Tyler, Tex. Thelma Saba's 11 years in public health nursing included direction of an inservice education program at a State hospital and before that a national leisure-time program for children. With 32 years of private medical practice, Jesse Goldfeder assumed his current post in 1958.

A graduate of the New York School of Social Work, Hannah Oppenheimer began her social work career as a child welfare worker in Alleghany County, N.Y., later serving as child welfare supervisor in the public welfare department in Oswego County in the same State. Two years ago, she joined the staff at the Huntington Family Center, where she gives therapy to families with many problems.

Since 1948, Milton J. E. Senn has been with Yale University, where for several years he has headed both the Department of Pediatrics of the Medical School and the Child Study Center. He specialized both in pediatrics and in psychiatry after taking his medical training at the University of Wisconsin. While a member of the pediatric staff of Cornell University Medical School, he became a Commonwealth fellow.

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GAPS IN STATE PROGRAMS FOR JUVENILE OFFENDERS

WILLIAM H. SHERIDAN
Assistant Director, Division of Juvenile Delinquency Service, Children's Bureau

WITH THE ADVENT of the juvenile court movement 60 years ago, a new legal process was created for the handling of child offenders. It was based upon a philosophy of treatment, of rehabilitation rather than punishment. Some lawyers refer to it as the doctrine of *parens patriae*. Others regard it as a method of providing individualized justice, requiring the following:

1. A judge and a staff identified with and capable of carrying out a nonpunitive and individualized service.
2. Sufficient facilities available in the court and the community to insure—
   (*a*) that the dispositions of the court are based on the best available knowledge of the needs of the child.
   (*b*) that the child, if he needs care and treatment, receives these through facilities adapted to his needs and from persons properly qualified and empowered to give them.
   (*c*) that the community receives adequate protection.
3. Procedures that are designed to insure that two objectives are kept constantly in mind, these being—
   (*a*) the individualization of the child and his situation; and
   (*b*) the protection of the legal and constitutional rights of both parents and child.[1]

During the last decade, the procedures and practices of juvenile courts have been under critical scrutiny. This interest has been reflected in appellate court decisions and in various law review notes and articles, as well as in the 1959 revision of the "Standard Juvenile Court Act" [2] and "Procedure and Evidence in the Juvenile Court." [3] This has been a constructive experience for the juvenile courts and has pointed the way to changes which should enhance their effectiveness and status throughout the country. In many courts, changes have already been made which have brought closer one objective of individualized justice: more adequate protection of the legal and constitutional rights of parents and child.

Legal protection, however, is only one of two elements of individualized justice. The second is equally important: protection of the child and the community through individualizing the child in treatment. This requires the provision of services and facilities adapted to various needs, staffed by persons qualified to use present knowledge of the behavioral sciences in the child's behalf.

It is about time we took a hard look at the second element of individualized justice by scrutinizing State and local programs available to the courts for the care and treatment of delinquent children. Adequate local probation services are vital to juvenile courts. However, probably as many as half of the courts have no such services. Even where probation services exist, high caseloads and lack of trained workers often negate their effectiveness. However, progress in improving these services, although slow, is being made with the support of local citizen and professional groups.

Unfortunately, this local interest generally does not extend to State programs. The old adage "out of sight—out of mind" applies in many States to the child who is placed in State care. This lack of interest seems as typical of professional persons who work with juvenile offenders in local communities as it is of the general public. For example, a list of 145 suggestions for workshop discussion at a recent meeting of a national organization composed of such persons contained only 6 topics concerned with State programs.

Yet the children in State care eventually return to local communities—some too soon because of the overcrowding in State institutions, some having

learned more about delinquency because of the poor institutional programs. Moreover, for a variety of reasons, many local communities increasingly must turn to the State for certain needed services, such as detention care and residential clinical facilities. The spread of metropolitan areas far beyond local political boundaries, the rapid expansion of our population, and its great mobility, all exert an increasing pressure upon our already inadequate programs, and indicate an urgent need to develop strong State programs to underpin local efforts.

For the most part, State programs for the care of delinquent children are still limited to the institutional care provided by State training schools. With few exceptions, the "treatment" programs in these schools go little beyond meeting needs for the care of children away from their own homes, some not even this far. This condition exists in spite of the sincere efforts of conscientious staff in many training schools. Some of the reasons can be found in factors beyond their control which pose almost insurmountable problems.

Training Schools

Most public training schools for delinquent children are "catch-all" facilities faced with the care of a heterogeneous population. The only common factor applying to all of the children in them is that each has committed an act, whether defined as delinquent or not, which has brought him under the jurisdiction of the juvenile court.

These young people range in age from 8 to 18 or 19, and occasionally even to 21; in intelligence, from the retarded to the superior; in experience, from the naive child who has only incidentally committed a delinquent act to repeaters with confirmed, sophisticated delinquent patterns; in personality, from the withdrawn to the highly aggressive, acting-out delinquent; and in treatment potential, from the youngster who wants help and can use it profitably to the one who rejects all help. The individuals in each of these groupings all have different potentialities and problems. Some of these children present programming difficulties because of physical handicaps or pregnancy. To adequately meet the program needs of each child in such a diverse population is not possible within a single institution.

Complicating the situation further is the problem of overcrowding. Four out of ten public training schools are caring for populations which exceed their stated capacity.[4] Because of overcrowding many schools return children to their homes prematurely in order to make way for committed children who are awaiting placement.

Expanding present facilities, however, is not the answer to overcrowding. Many of the institutions are now too large, and specialists in group care, who have recommended a maximum capacity of 150, have pointed out that, unless their size can be limited, the therapeutic atmosphere and program necessary for individualized treatment cannot be maintained.[5] The fact that the returnee rate is considerably higher among larger institutions than among smaller ones seems to support this.[4] Ways and means need to be found to limit training school populations to a size appropriate for treatment and to children more homogeneous in their treatment needs. A first step in this direction is to review the selection process.

Primary Selection

Since, under our constitutional government, rights cannot be denied without due process of law, the primary intake control for State care, which in most States is the training school, rests in the judicial branch of government, specifically in the juvenile and family courts. The gross criteria at this point are age and the commission or omission of an act, the nature of which places the child under the jurisdiction of the court.

Even these criteria vary from State to State and sometimes within States, since the upper age jurisdiction of these courts varies from 16 to 21. It is 18 in about two-thirds of the States. In some States where the upper age jurisdiction of the juvenile court is 18, the court can not only commit a youngster up to this age, but even youngsters over 18 whose delinquent acts were committed before reaching that age. Since, in most States, court orders vesting legal custody may continue in force until the child reaches majority, the upper age of the school populations, theoretically at least, can be 21.

Although the age criterion is the roughest of guides and has little value as a selective factor for the institutional population, the law needs some readily ascertainable objective standard to confer jurisdiction in the courts. Age, therefore, is a necessary gross criterion at this time for a program of handling juvenile offenders, as it relates to court jurisdiction.

A finding that the child has committed a delinquent act or has failed to do something he is required to do is also a primary prerequisite in establishing the jurisdiction of the court. The nature of the child's act is also an important factor in determining whether State care is required in order to protect

the child or the community, but in this respect it should not be the controlling factor but only one of many others which need to be examined by social and clinical study of the child. However, none of the factors which indicate whether State care is called for should necessarily be controlling as to the nature of the care needed. While such factors may be of help in determining this, other factors are equally important.

Procedures for Refinement

The use of certain procedures can be steps toward the refinement of the process in which primary selection is made.

Social and emotional maturity are not achieved at any given chronological age. Whatever age is specified as the upper limit of juvenile court jurisdiction causes problems. There are always some youngsters below this age limit who, because of their personality and degree of maladjustment, cannot, even with the advances that have been made in treatment knowledge and techniques, profit from present programs designed for the treatment of adolescents. Because of this, many State statutes provide for flexibility through the waiver power which permits the court discretion in exercising jurisdiction. This, under certain conditions, gives the juvenile courts the option to retain jurisdiction or to transfer the child to a criminal court.

While the power to waive in cases involving felonies was incorporated in the first Standard Juvenile Court Act (sec. 12),[6] as well as in the latest revision (sec. 13),[2] the Children's Bureau had recommended a more flexible provision to the committee preparing the latest revision of this model statute. Under this proposal, the courts could also waive jurisdiction over older youth—18 to 21—for offenses less than felonies as well as jurisdiction over children over 16 who are already under the care of an agency or institution if it can be shown they were not responsive to treatment. In order to prevent abuses of the waiver process, the provision would require that additional specific findings be made prior to waiver.

Use of such a waiver provision would weed out the older aggressive, acting-out delinquents who need continuing care in secure custody—in most States probably a relatively small number of the juvenile offenders. Effective use of the waiver would, in a large measure, be determined by the adequacy of the court staff.

Another provision in the 1959 Standard Juvenile Court Act (subdivision 2, sec. 24) prohibits the commitment of children who have come under the court's jurisdiction because of neglect or conduct which would not be criminal if committed by an adult, to institutions established primarily for children who commit acts which would be crimes if committed by adults. Such a provision might help to refine the selection process; but in many instances it could be circumvented by changing the allegation from "incorrigibility" to specific law violations which often have been part of the behavior leading to an incorrigibility petition.

Questionable Methods

Some of the legal provisions resorted to in order to control training school populations are subject to question. For example, a number of States have established, either by statute or executive order,[7] minimum ages of 10 to 12 for children who can be committed to the State training schools. As previously pointed out, any attempt to use age as an absolute control is highly questionable. Also questionable is the assumption that all delinquent children under 10 or 12 do not need institutional care. When there is no facility available for delinquent children other than the State training school and a child is in need of group care outside of his home, such a provision may have the effect of denying the child care and treatment. In any event, the type of foster care best suited for the individual child should be established by careful social and clinical study.

In spite of the waiver provisions in their statutes governing juvenile courts, a number of States are bypassing the judicial process through the practice of transferring youngsters from an institution for juvenile delinquents to a penal institution for persons convicted under criminal procedures. This far too common practice has been unchallenged until recent years. A study of 139 public institutions made several years ago indicated that 40 percent had the authority by legislation or executive order to transfer their charges to penal institutions.[8]

This practice is unsound both legally and socially. Not only does it deny the transferred youngster, who thus becomes a "prisoner," the protection of criminal proceedings, including a jury trial, but it also undermines the philosophy of the whole juvenile court movement, which was established primarily to protect the child from contacts with adult criminals and from being stigmatized as a convict. Recently there have been several court decisions forbidding such transfers;[9] others have upheld the practice.[10]

Both the 1959 revision of the Standard Juvenile Court Act [2] and the new Standard Family Court Act [11, 12] provide that "An institution to which a child is committed . . . shall not transfer custody of the child to an institution for correction of adult offenders."

The laws of a few States permit the juvenile court to commit a child directly to an adult penal institution on a finding of delinquency. While this practice is as unsound as the practice of transferring a child to such an institution, it was recently upheld in Ohio where the court of appeals was reversed after granting a writ of *habeas corpus*.[13]

The American Psychiatric Association has suggested that children be admitted to training schools on a voluntary basis by agreement with parents.[14] This proposal has not gained any degree of acceptance among social workers or judges.[15] Many factors argue against such a proposal. Parents are often ambivalent and, since the agreement could be terminated at any time, would in many instances fail to leave their child in the institution long enough for treatment to be effective. Many communities are without diagnostic services to determine the child's need for such care, and there is always danger that undue influence or coercion will be used in either placement or release. It cannot be presumed that parents are always acting in the best interest of the child nor that the public interest will always be considered. More than an agreement seems necessary to protect the rights and interests of both the public and the child. Moreover, effective program planning and coordination require a more consistent formalized procedure.

These arguments do not imply that service and care for a delinquent child, either under State or local auspices, should never be available except under court commitment. Certain types of care or service might be provided by agreement with parents, such as casework services in situations involving child-parent conflict, or residential diagnostic study. However, generally continuing care in the State program for delinquent children should be provided only through court commitment.

The court's role as the *primary* intake source for State services and care is necessary since only through court action can the legal custody of a child be changed. Many courts, however, are not able to discharge this primary responsibility adequately because they do not have the necessary auxiliary probation and clinical services.

Even with such services available to the court locally, there is great need for a *secondary* screening mechanism. This is true for several reasons. Such a mechanism could be helpful in meeting the problem of diversity in training school populations. It could compensate for defects in the selection process due to inadequacies in local services. And, increasingly important, it could make for efficient administration and effective coordination within the State program as the States diversify and expand their facilities and services for delinquent children.

Custody to State Agency

A secondary screening mechanism can be established through a change in the commitment process, making it possible to commit the child not to a specific facility but to the department of the State government responsible for the administration of the State's program for the care and treatment of delinquent children, often referred to as the "parent agency." Provided for in the Standard Juvenile Court Act [2] and the Standard Family Court Act,[11] such a procedure has in fact already been in effect for some years in several States—California, Delaware, Idaho, Illinois, Massachusetts, Minnesota, Texas, Washington, and Virginia. In other States it will require changes in the structure of the executive branch of State government, particularly in States where the responsibility for administering the State's program for the care and treatment of delinquent children is divided between two or more agencies or boards.

The vesting of legal custody in a specific State agency is most important from the standpoint of individualized treatment. As pointed out earlier, the specific nature of the treatment or care needed by a child is not necessarily determined by an adjudication of delinquency. Nor do the child's treatment needs remain fixed or constant; they shift and change as the child develops during care and responds to the treatment he is receiving. Therefore, a variety of facilities or services are required not only for determining changing needs but also for meeting them. These are not determinations which can be made by courts unfamiliar with the day-to-day treatment needs of the child and which may be several hundred miles away from the child after commitment. They can best be made by representatives of an agency having legal custody for the child, who are knowledgeable about the services and facilities which it has at its disposal, and who are aware of the child's changing needs.

Some juvenile courts have questioned this type of

commitment procedure as well as the granting of authority to the State agency to make certain treatment determinations. However, as long as the right to due process is preserved through judicial action, these practices do not impinge on the constitutional function of the judicial branch of government.

The Supreme Court of Illinois has held that "The determination of where the criminals shall be placed or committed is wholly within the legislative authority; and except as the legislation has conferred, the courts have no discretion in the matter." [16] In the same decision, the court said, "Provisions of the Youth Commission Act under which the Commission may place youths committed to it under indeterminate sentences in appropriate institutions, order their release or parole, or discharge such persons from custody, do not involve an unlawful delegation of judicial power to an administrative agency. . . ."

The administrative agency, however, should not be given carte blanche. Its authority should be limited to the powers of a legal custodian, the parent or guardian and the court retaining those powers deemed appropriate.[1] Procedural safeguards governing the operation of the agency should be established,[12] and provision made for court review upon request of child, parent, or guardian of certain major treatment determinations of the agency.[2]

The law should require the parent agency to accept legal custody of the child and to provide care and treatment when the kind needed is consistent with the agency's responsibilities.[1,12] In the interest of the public and the child, the agency should not be permitted to "close intake." [17] No minimum age limitation on commitment should be imposed since this could have the effect of denying the child necessary care or the community protection.

Under this type of commitment, the intake of each specific facility would be controlled by the parent agency. Thus the initial placement and, if indicated, later transfer of the child to another type of facility for children could be based upon the individual child's needs and available resources. Children who, after study, are found not to need treatment in foster care could be returned home under supervision. It should not be necessary, however, for all children to be routinely processed through a reception and diagnostic center. Some courts have fairly adequate probation staff and clinical services. When the study and diagnosis presented to the court are adequate and reflect the need for a specific type of care, the court might well recommend the specific facility. This recommendation could be reviewed by the State agency, possibly by its field staff, and arrangements made to send the youngster directly to the agreed upon facility.

Comprehensive Programs

In the absence of a variety of treatment resources, a secondary screening mechanism can serve little if any purpose. Therefore, action to secure such a mechanism needs to be complemented by action to develop a statewide program of diversified services and facilities for the care and treatment of delinquent children and youth. Ideally, in addition to training schools, which might be set up on a coeducational basis, such a program should include diagnostic study centers, detention facilities, small residential treatment centers for seriously disturbed children, facilities for the care of defective delinquents, forestry camps, foster family homes, and group homes. Casework services should be available to delinquent children whether in or out of their own homes.

Such a diversified program can help meet the problem of overcrowding and permit the establishment of more homogeneous treatment groupings of delinquent children. It can help attain the second goal of individualized justice by assuring for all delinquent children the individualized care and help they need to develop maturely.

There is ample evidence of the failure to develop such programs. For example, many training schools have youngsters who need the kind of training provided in a facility for the mentally retarded, but who cannot be sent to the State schools for the retarded because of their long waiting lists. The same is often true of the emotionally disturbed or prepsychotic youngsters who need treatment in a hospital or other specialized facility. In the State institution for delinquents not only are mentally defective or sick children not getting the specialized training or treatment they need, but they add to the difficulties of operating a therapeutic and educational program for others.

The heterogeneous populations in training schools also reflect the disparity in local services. It is not uncommon to find children in training schools who could have remained in their own homes had adequate probation or other treatment services been available in the community.

While many large urban areas have been able to develop local institutions and other intermediate types of care and service for delinquent children presenting less serious problems, smaller commun-

ities in rural areas have had to depend upon the State institutions for care for all of their delinquent youngsters. As a result, the young people coming from large urban areas are more likely to be older and more sophisticated in their delinquency pattern than those coming from small communities in rural areas. Protecting the younger, more malleable youngster from the influence of the more hardened delinquent is an institutional problem of no small proportions.[18]

A State agency into whose care delinquent children are committed needs to work not only for the diversification of its resources for treatment and care but also for the development and improvement of local community services. One way it can help is through the provision of technical assistance and of training programs for personnel.

In a State program for child offenders, structure and procedures alone, regardless of how sound, will not achieve the goals of individualized justice. Strong, alert, professional leadership is a must. The support of the executive and legislative branches of government as well as that of all citizens—professional and lay alike—is equally vital. For, without effective leadership and adequate financial support, the goals of individualized justice for children cannot be attained.

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[1] U.S. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau: Standards for specialized courts dealing with children. CB Publication No. 346. 1954.

[2] Committee on the Standard Juvenile Court Act of the National Probation and Parole Association (now National Council on Crime and Delinquency) in cooperation with the National Council of Juvenile Court Judges and the U.S. Children's Bureau: Standard juvenile court act. *National Probation and Parole Association Journal,* July 1959.

[3] Advisory Council of Judges of the National Council on Crime and Delinquency: Procedure and evidence in the juvenile court. New York. 1962.

[4] U.S. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau: Statistics on public institutions for delinquent children. CB Statistical Series No. 59. 1958.

[5] ———: Institutions serving delinquent children: guides and goals. CB Publication No. 360. 1957.

[6] National Probation and Parole Association (now National Council on Crime and Delinquency): Standard juvenile court act. New York. 1927.

[7] U.S. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau: Some facts about public training schools for juvenile delinquents. CB Statistical Series No. 33. 1956.

[8] Rowland, Robert L.: Public institutions for delinquent children, 1956. U.S. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Statistical Series No. 48. 1958. (Out of print.)

[9] *State ex rel. McGilton* v. *Adams,* 102 S.E. 2d 145 (W. Va. 1958); *White* v. *Reid* (D.D.C. 1954), 125 F. Supp. 647, 126 F. Supp. 867; *Stinnet* v. *Hegstrom* (D.C. Comm. 1959), 178 F. Supp. 17; *Cogdell* v. *Reid* (D.D.C. 1954), 183 F. Supp. 103; *Knutter* v. *Reid* (D.D.C. 1960), 183 F. Supp. 352.

[10] *Merton* v. *Heyden,* 142 A. 2d 37 (Maine 1958); *Sonnenberg* v. *Markley,* 289 F. 2d 126; *Clay* v. *Reid* (D.D.C. 1959), 173 F. Supp. 667, 272 F. 2d 527.

[11] Committee on the Standard Family Court Act of the National Probation and Parole Association (now National Council on Crime and Delinquency) in cooperation with the National Council of Juvenile Court Judges and the U.S. Children's Bureau: Standard family court act. *National Probation and Parole Association Journal,* April 1959.

[12] U.S. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau: Proposals for drafting principles and suggested language for legislation on public child welfare and youth services. 1957. (Multilithed.)

[13] *In re Darnell,* 173 O.S. 335 (1962).

[14] Ad Hoc Committee of the American Psychiatric Association: Training schools for delinquent children. American Psychiatric Association, Washington, D.C. 1952. (Out of print.)

[15] U.S. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau: Report on the national conference on juvenile delinquency, June 1954, Washington, D.C. 1954.

[16] *People* v. *Fowler,* 151 N.E. 2d 324 (Ill. 1958.).

[17] *State ex rel. Schwartz* v. *Haines,* 179 N.E. 2d 46 (Ohio 1962).

[18] Grosser, George H.: The role of informal inmate groups in change of values. *Children,* January–February 1958.

Every community, urban and non-urban, has as much delinquency, as much social pathology as it deserves. If dependency rates are higher in our urban cities, if delinquency rates are shocking, it is basically because our urban communities have not learned what we are teaching the people of underdeveloped countries—that social planning and development, the provision of preventive and rehabilitative social services, must accompany planning and development on the economic front.

James R. Dumpson, New York City Commissioner of Welfare, to the 1961 meeting of the American Public Health Association.

"Whose crisis?" asked the staff of an evaluation center after they reviewed referrals for . . .

EMERGENCY CARE OF DISTURBED CHILDREN

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AMONG the many problems facing services for children, none is more critical than the necessity to operate from crisis to crisis. Under such circumstances the long-term needs of the child and the real nature of the crisis may be overlooked. Although the extent of the child's disturbance and past instances of failure of services in dealing with it may be clear, situational pressures compound past errors and the result is frequently a referral for emergency institutionalization. When this occurs, the receiving institution often is intended not as a treatment resource, but as a convenient custodial center for containing children whose behavior has become disturbing to the community. Most mental hospitals have among their population a sizable number of children who have been "dumped" in this manner, without adequate preliminary study or planing for their return to the community.

In order to permit more selective use of the limited institutional settings available to emotionally disturbed and defective children in the Philadelphia area, the Pennsylvania Department of Public Welfare has established the Eastern Diagnostic and Evaluation Center, an outpatient service for children, without direct access to inpatient beds. Located in the city, the center serves an area having a population of about 3½ million persons. It accepts referrals only from professional sources and only when other community resources are inappropriate. A basic intent of the center is to function collaboratively with State, community, and private health, educational, and welfare facilities in dealing with complex, or chronic, diagnostic or dispositional problems. Because of the center's screening function, most referrals to it have constituted a "last ditch" effort on the part of the community to cope with a severely disturbed child or situation.

The community in which the center is located is probably typical of most large metropolitan areas in having a comprehensive network of social agencies which provides a wide range of services for children and their families. These services include many hospitals and clinics offering medical care or psychiatric treatment on an outpatient basis, but few facilities suitable for inpatient psychiatric care of children. There is a modern facility for the short-term detention of children in trouble with the law, which unwillingly finds itself providing care to children with varying degrees of mental retardation or emotional disturbance. Several child-care facilities which offer residential care and casework service on a long-term basis, with psychiatric consultation are also available, but they serve only a select group of children whose degree of disturbance is not so pronounced as to prohibit attendance at public schools nor to require maximum supervision and control.

Based on a paper presented at the 1962 annual meeting of the American Orthopsychiatric Association.

Because of the number of emotionally disturbed children in the community, the severity of their problems, and the inadequacy of services for them, the center has received many so-called emergency referrals in which the request is for immediate admission to a State hospital or a State school for the retarded. The child is always described as severely disturbed, the family as more or less disintegrating, and the community as "up in arms." Invariably, these referrals have in common a note of urgency bordering on panic.

In each instance, an emergency clearly exists. However, we have found that these emergencies seem to be as characteristic of the problems of services—both numerically and qualitatively—as they are of the extent and nature of the child's disturbance.

Source of Emergencies

Our experience indicates that psychiatric emergencies in children are the culmination of a complex interaction of forces in which the child's disturbance plays an important but not usually a primary role. We have found that emergencies are of several types, each of which presents unique problems in immediate management and subsequent study and disposition. There are cases of acutely disturbed children in which the immediate need is for clarification of the caretaking situation, location of parents, and mobilization of resources or individuals in the community. There are other cases in which the child's behavior warrants immediate therapeutic intervention. Other emergencies result from acute family or community breakdown, which in addition to introducing stress with which the child is unable to cope, constitutes a critical problem in community service responsibilities. In many of these so-called "pressure" cases, the degree of disturbance in the child, while not primary, is sufficiently critical to warrant immediate study. Still other cases become emergent only after diagnostic study is begun.

All emergency cases, however, appear to have in common an enduring and pervasive disturbance in the child which has been the focus of past ineffective planning on the part of the family and of services. There is a common history of expedient solution to past crises, which have broken down and increased the child's disturbance as panic spreads through the surrounding matrix of personal and professional supports. Each case thus presents an individual problem of evaluating the absolute needs of child and family after factors of secondary distortion have been allowed for.

The nature of childhood dependency is such that evaluation of the emotionally disordered child must include evaluation not only of the family caretaker but also of the constellation of services involved with family and child. We have found that the dumping of children into institutions is abetted by services which on one day view behavioral aberration in a child as a minor problem in social adjustment, and on the next as a major psychiatric disorder.

Emergency Cases

In a 13-month period, during which approximately 550 cases became active with the center, 42 were identified as "emergency." We have analyzed these through data obtained from a standardized intake information form, a semistructured initial contact interview, other case material, and correspondence. Our analysis reveals few features which differentiate these cases from nonemergency cases, other than the fact that the disturbed child is interacting with the community services in a way that requires immediate, decisive intervention in order to maintain some semblance of equilibrium, for child and community.

The 42 children in these emergency cases included 22 boys and 20 girls. Their ages range from 5 to 18, only six being younger than 11. Of these, four were boys between 5 and 8; two were girls of 9 and 10. There were three times as many white as nonwhite boys. Among the girls, the proportion of white and nonwhite is in the opposite direction: two to three. Of the total group, roughly half of the children were in the 13- to 15-year age range.

Twenty-nine of the 42 children were living in their own homes at the time of referral. Four children were in foster family homes or living with relatives. Nine were either hospitalized or institutionalized in settings which were no longer considered appropriate.

In school, 20 of the children were in grades normal for their age. Four were one to three grades behind their age-grade expectation. Seventeen were in special classes or excluded from school. Only one was a preschool child.

The overwhelming number of these children could be described as situationally deprived and dependent. Almost two-thirds came from families with incomes less than $4,000 per year. More than a third were from families supported primarily by public assistance grants or Government pensions.

Registrations with the Social Service Exchange indicated that the families of three-fourths of these children were known previously to social agencies.

One-quarter of the families had more than five registrations, which means that they had been through the intake department of one or more agencies at least six times. One family had 38 registrations.

Forty-seven percent of the referrals for emergency service came primarily from medical sources; 5 from family physicians, and 15 from hospitals or outpatient clinics. Approximately 25 percent came from private psychiatrists (7) or mental health clinics (3). Of the remaining 25 percent, five came from the local public agency serving dependent children and three each from other social agencies and the schools. Among the symptoms reported by the referral source, the most common was aggressive behavior—listed in approximately one-half of the cases. Bizarre behavior was only slightly less common. Suicidal or homicidal threats were reported in only one-sixth of the cases. Sexual acting out as a prominent symptom was mentioned in only five of the referrals. In about half the cases, the child was a severe problem to the school, was involved with the court, or was the focus of complaint from the community because of aggressive behavior toward peers and younger children.

Only 2 of the 42 children had received psychiatric treatment prior to the crisis and in these cases the treatment had been received within 2 years of the time of present referral. In five other cases psychiatric treatment has been sought but not persisted in. In about half the cases, there had been medical or psychiatric consultation or attempt at treatment just before the referral of the case to the center. In most of the latter, medication had been prescribed and in a few instances the child had been receiving a tranquilizer or sedative for several weeks prior to the referral. In only a small number of these children had medication ameliorated the behavior.

A review of the case records of the 42 children indicates that in nearly every instance the child's disturbance was a chronic and pervasive one, preceding the current crises by several years. In the majority of cases, there had been an indication of a disturbed maternal-child interaction in infancy; in at least three cases, for example, the mother had considered criminal abortion early in pregnancy.

The typical picture in the families of these children was one of extreme family instability, currently and in the past. This was reflected in the many contacts these families had had with welfare agencies, some of them dating back as far as 25 years. Severe marital conflict was described in most cases, and a history of mental illness in one of the marital partners was an equally frequent finding. The behavior of parents in the emergency situation reflected this instability; it was not unusual to note disorganized behavior of near-psychotic proportions in one or both parents. In only two cases did it appear that there was a reasonably stable family situation.

In a number of instances, there was, at the time of referral, overt conflict between different child welfare services with respect to responsibility for the child's custody.

Interviews and Disposition

The nature of an outpatient psychiatric service geared to handling such emergencies is dictated by community pressures and understanding, the existence of other services, and the availability of staff time. Our service, therefore, should be regarded as an evolutionary attempt to cope with a specific pattern of need in a particular community. It might differ in another community or under other circumstances. In developing it, we needed to consider both the immediate and long-range needs of child, family, and community, within the context of the limited facilities for children with severe emotional disorders.

Our professional team includes the disciplines of child psychiatry, pediatrics, clinical psychology, and psychiatric social work. Special laboratory, neurological, and medical consultation services are available as needed. Team members participate flexibly in response to the needs of the case. In any specific case all variations of child, parent-child, family-child, and sibling-child interviews may be held with one or more professionals and with a timing that is individual in every case. Each interview has structure and focus, but these may be altered in an interview by professional communications on the case.

We have found that certain areas must be covered in interviews and examinations in order to assess the nature and degree of the crisis. Viewing each crisis as resulting from a multiproblemed interactional disturbance between the child, the family, and the community, we initially attempt to obtain a comprehensive overview of the situation. We do this through the use of a semistructured interview that systematically samples the adaptive behavior of the child and caretakers, currently and over the course of the child's development. We also learn what we can of the past experience of the mother, especially in relation to her methods of coping. Also included in this exploratory interview is a consideration of the

ways the members of the family receive emotional and social support, and the demonstrated capacities of the child and family to utilize support from others.

In our contacts with the child, we make every effort to evaluate his present disturbance in relation to his age and developmental stage, his endowment, and his past interaction with the environment. During this process, brief therapeutically oriented intervention is carried out in relation to presented symptoms such as attention getting, excessive demands, and control of others. For example, rage reactions and other uncontrolled behavior may be dealt with by protectively holding and comforting the child. Medications are stopped which depress consciousness and confuse integrative functions and evaluation of transactions between self and others. There is a studied attempt throughout to restore a more normal interactional pattern to child and family by decreasing elements of panic.

Simultaneous with our attempts to obtain a comprehensive view of the child in his family, we also try to find out about the relation of the present crisis to the community. Thus we routinely collaborate with other agencies who have serviced the family, including the school, and the court if it is involved. We also communicate with the family physician both to obtain information and to determine whether he is a possible source of support to the family. Usually, a preliminary alert is given to possible facilities for emergency admission.

When it is clear that the situation is, in fact, too much for the child and his support system, we recommend hospitalization for him, telling both the child and his parents. When hospitalization is not regarded as immediately necessary, additional contacts with the child and family are scheduled—sometimes on a daily basis—in order to obtain perspective in regard to immediate and long-range goals. In either event, direct and frequent communications about the developments in the case are furnished to the likely inpatient service.

The 42 emergency referrals had a variety of dispositional outcomes. Immediate hospitalization was recommended and effected for 10 of the children. In each instance, the child was hospitalized in a facility planned for adults—a sad commentary on the adequacy of community facilities. In 27 out of the 42 cases, there was time to hold more than the initial interviews with the child and family. In six of these cases, admission to institutions was arranged within 5 days to 2 weeks. Five of the six children were hospitalized in an adult setting; one was placed in a State school for the mentally retarded. In five other cases, the brief psychotherapeutic contact with the center proved adequate for meeting the crisis, so that the child could be referred for service to more appropriate community services or the family could continue to manage without further appointments. So far as is known, the children in these cases were not subsequently hospitalized, at least for the specific condition for which they were referred to us.

Half the cases (21) proceeded into a complete diagnostic study in the center extending from 1 to 8 months before disposition. In three of these cases, the children were eventually admitted to an adult State hospital setting, which was considered appropriate, though not ideal, for their needs. Six of the 21 children with diagnostic studies were placed in a children's setting in a State hospital; 4 were sent to State schools for the mentally retarded; 2 children were admitted to psychiatric wards in community general hospitals because of acute exacerbation of symptoms during the course of the evaluation. On the recommendation of the center, two children were committed to correctional schools by the court, one child registered at a psychiatric outpatient clinic, and one was placed in a foster family home and one in a group residence. One child was continuing through complete diagnostic evaluation by the center, with the contacts geared to providing specific supports to the family during the management crisis.

In a few of the cases, the nature of the Evaluation Center's contacts with family and child seems to have introduced a level of stability into their functioning which, when coupled with more adequate use of community resources, seems to have resulted in long-range amelioration of the disturbance. In most cases, however (31 out of 42), complying with the initial request for hospitalization was the only sound solution. However, in these cases, the psychotherapeutic intervention of the center made possible the use of the inpatient setting together with sustained community contact with the child and family.

Creation of Emergencies

The psychodynamic value of the center's service seems not to rest entirely upon the availability of psychiatric beds for children, but rather upon consideration of the individual case needs in order to provide an organizational experience for family and child. The view taken by the professional staff is that constructive disposition of a case is not possible until the family's capacity to cope with problems

had been evaluated and their perceived social supports enhanced. For example:

The center was asked to evaluate the case of a 15-year-old boy who had been referred directly to a State hospital because of his behavior in a local detention home. He had been considered a behavior problem in school for several years, and a year ago had been suspended because of sexual misbehavior and deteriorating schoolwork. At about the same time, he had been arrested for minor thefts and placed on probation with his parents. The family was described as "substandard," with a long history of contacts with various social agencies and the courts. The father was said to "appear to be mentally ill." Little hope was offered that the mother would participate in planning for the child.

When the mother was interviewed, after some difficulties in arranging an appointment, she said she was afraid her son would be put in a mental hospital with "older people who are violent and senile." She was accompanied by her husband who she said had suffered a serious head injury a year before which had left him with a severe memory disturbance and periods of extreme irritability and confusion. She told of frequent moves and longstanding economic deprivation which had only recently improved as a result of her employment. Her description of the interaction, with respect to this child, included extreme differences between herself and her husband in relation to the giving of affection, guidance, and discipline, with the boy caught in the middle. His current placement in the detention home was his first separation from the family.

Recognizing the many stresses operating on this mother, we were able through supportive therapeutic intervention to involve her actively in planning treatment for her son as a positive growth experience, rather than as an authoritarian decision that further emphasized her feelings of failure and frustration.

As this approach has been examined and developed, it has become clear to the staff that emergencies are less often created by radical changes in the state of the child and more by sudden alteration of the support from community services as perceived by the family. The groundwork for sudden changes in the support available to the family is laid when the initial evaluation made by a child welfare service is inadequate. When this has been so, common stresses such as a death in the family, moving, divorce, and economic catastrophe become the focus of radical changes in the agency's perception of the needs of the case, followed by sudden incapacity to support the family. Marginal caretaking situations then break down when agency support is withdrawn.

We also found that stress was often introduced unwittingly by a service acting on its own without knowledge of, or with little regard for, other services also involved. An unplanned change in foster placement, the rejection of the family by a service, the dismissal of the child from school, or the termination of some other plan for care or treatment were among the contingencies noted. For example:

After 5 years in a private school for the retarded, a 12-year-old girl was precipitously discharged to her family because of "destructive behavior." For a period of 2 months afterward, the parents frantically attempted to obtain assistance in her management or placement from physicians, influential persons, agencies, and the local school district. The mother, who had a history of periods of severe depression, was completely unable to cope with the child's voracious appetite, periodic hyperactivity, and excessive demands. At the time of referral, the mother was so "nervous and fed up" that she would "walk out of the home and let the child take over completely." The outpatient department of a local hospital and a private physician were unsuccessfully attempting to control the child's hyperactivity with medication and the provision of general support to the parents. The child's disruptive behavior was jeopardizing her participation in a local day-care program for retarded children, which had been arranged by the local school system. Urgent requests for institutionalization had been made indiscriminately to a variety of State institutions and to offices. A clear emergency obviously existed in terms of the child's behavior and the family's coping ability, as well as in the services that had been involved in attempting to provide interim services.

In our pattern of community health, education, and welfare services for children, each service too often seems to regard itself as independent of all others. We found that a change made by one service may set in motion a chain reaction whereby all services become overstressed and unable to be of help.

A review of our emergency cases indicates that our present dilemma derives from the culmination of past failures to recognize and cope with disturbances in children, in families, and in community services. These cases reflect the need for an examination of patterns of service in relation to needs of children. They show all too clearly the lack of a continuum of services suitable to a wide range of childhood problems and the tendency to view treatment and management as a dichotomous choice between inpatient and outpatient. They reveal the inevitable and predictable result of service patterns which make the child's disturbances conform to the available settings.

It seems unlikely that much can be accomplished immediately to change materially the factors contributing to emergencies. On the other hand, it seems quite possible to develop an individual service's capacity to cope with emergencies. The provision of support, immediate availability of service, and continuing contacts and communication among services are areas in which emergency situations reveal the most deficit. There seems to be a good deal of wishful thinking associated with emergencies that, instead of alleviating, may prolong and exaggerate them. A panic response on the part of a service to acute disturbance in a child may contribute immeasurably to its outcome. Our experience suggests that children and families in an emergency situation may have potential for coping that is not always recognized. It is, therefore, necessary to provide a comprehensive, professional approach that focuses attention on the needs of the child and family, and the capacities of his environmental supports; and one that consistently views immediate institutionalization as only one of several possible solutions to a crisis.

How foster parents can be helped to see the sharing aspects of their role through understanding . . .

THE MOTIVES AND CONFLICTS IN FOSTER PARENTHOOD

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IN RECENT MONTHS there has been a new focus in foster home supervision within the Division of Children's Services of the St. Louis Department of Welfare. This had its beginnings in the group meetings for foster parents.[1] While the participants conveyed a real interest in being foster parents and a desire to do their job well, they repeatedly expressed a confusion about their role in caring for a child within the agency structure. Consequently, an attempt was made to conceptualize the foster-parent role.[2] The result was a concept of the foster parent as a partial parent, playing an "as if" role toward a child for a temporary period of time, and at all times having a shared responsibility toward the child. The present article will deal with some implications of this concept for work with foster parents—especially foster mothers. The important role of the foster father will also be considered, though more briefly, for this is somewhat less well-defined.

Historically, and all too often in the present, foster parents have been looked on as caretakers of the children for whom the agency has responsibility. The foster home is thought of simply as a resource, a place to lodge the child. And this it is in a physical sense, but we cannot effectively use this resource if we do not understand the components within it. Foster parents are not just caretakers of children, they are individuals in their own right; individuals with needs, desires, feelings, attitudes, and values; individuals desirous and capable of giving to a child; individuals living within a family and a culture. Unless the caseworker has this concept of the foster parent—that of an individual enacting a role as one human being in relation to another—he will not use the resource correctly.

The foster mother is, then, an individual and the particular role that she is playing toward the child is that of a substitute parent. This is very different from being a caretaker, because the role of parent, or a substitute parent, brings with it many deeper considerations than just taking care of a child. In addition to giving food and lodging to the child, the foster mother will be giving of herself through love and emotional investment; she will be teaching the child values, attitudes, and patterns of behavior. In other words, she will be acting as a mother.

The foster mother actually plays another role within her status as foster parent, her role with the agency. In this context, also, she must not be thought of simply as a resource, but as an individual giving valuable service to an agency. This very definition of "foster parent within the structure of an agency" means that the care of the child is a responsibility shared between the foster parent and the agency. Thus, the foster mother is a member of a team whose

interest is the well-being, health, and growth of the child. She participates in this sharing through her work with the caseworker.

Part of this sharing with the agency involves the natural parents, a fact which also affects the foster mother's role with the child. She can never be a "real" or "only" mother of the child because the presence of the natural parents in fact or in the mind of the child makes this impossible. Thus, the foster mother not only shares the child with the agency but with the natural parents as well—not only in the present but also in the future.

Thus, the foster mother is a partial parent and possibly only that for a time. This makes her role one of the most difficult any individual can be asked to play and one that raises many questions. How can a foster mother invest emotionally in a child and have the investment come to naught when the child is moved? Why would she suffer the pain that comes with the loss of a child, an experience that is so frequently a part of foster parenthood? How can she be a mother and not a whole mother? How can she want and love a child and not have it belong to her? In order to answer these questions, we must consider some of the motivations that lead individuals to offer to board a child.

Foster Parents' Motives

Motivations that lead women to apply to become foster mothers are, at present, not well-defined, but we may assume that the most obvious and consistent of these is the applicant's desire for a child. Dorothy Hutchison, in her book, "In Quest of Foster Parents," points out that the applicant always asks for a "baby" in her request regardless of the age of the child she desires.[3] This means that she is asking to play the role of a mother toward the child, to love it, to have it belong to her, to take care of it, and to be needed by it. There is a strong need of possession in many of these requests which is often directly expressed. Applicants frequently make such statements as "I want a child I could treat and feel like one of my own," or "I want a child that I would love like my own," or "being a foster parent is the same as being an own parent, giving love and care," or "being a foster parent would be the same as being his own mother and father."

The important point here is that applicants for foster children make a request for a child within the frame of reference of natural parenthood which is often their only basis of experience in caring for children. This is consistent with the applicant's desire for a foster child as an expression of her need for a baby, another child she has produced herself; in other words, an expression of her fertility. Foster mothers express this desire repeatedly, not only at the time of application but also at the time of placement. Caseworkers often hear such expressions as "I love him like my own" or "I can't remember my life without him." A great part of this denial of the agency's and natural mother's role in the life of the child is based on the foster mother's need to feel that she has produced the child. The fantasy of having produced the child is often clearly revealed when the foster mother must be separated from him. Many foster mothers are rather successful in maintaining this fantasy and then react to separation as if it were death.

Take, for example, Mrs. D:

Mrs. D applied for a baby to board when her own three children were older—one married and out of the home, the other two, teenagers. An infant was placed with her directly from the hospital on a preadoptive boarding basis. From the beginning, the caseworker warned her that the baby eventually would be placed for adoption, which would mean his permanent separation from her. The caseworker visited the foster home consistently at weekly intervals to share responsibility for medical planning with Mrs. D and try to make the role of the agency and her own role as a foster mother real to her. As time went on, however, it became evident in the way Mrs. D handled the baby and talked about him that she had made him her own.

When the adoptive placement was finally made, Mrs. D found separation from the baby extremely hard to take and told the caseworker that she felt that he had died. She sobbed, grieved, and mourned as if she had, indeed, been faced with death. The caseworker spent considerable time with her, supported her, and as Mrs. D's grief subsided, talked about the meaning of foster parenthood—the pleasures of giving to a child as well as the pain of giving one up.

In asking for a foster child, the applicant is expressing many other needs and desires than her own need to have a child. Among the most positive of these is the desire to extend to others the satisfactory experience of mothering she gave to her own children. She may also need to mother a child of the opposite sex than her own child or children. Other motives may be less positive, sometimes stemming from a sense of failure with her own child—a desire for another chance to succeed as a mother, a desire to gain pleasure from a child which she did not receive from her own child or perhaps from anyone else in her life, an attempt to assuage guilt at not having more children of her own, or a means of giving her husband a child.

Some mothers may mask their emotional needs in their requests and ask for a child merely as a companion to their own child or as a means to make some "pin money." Others may conceive of themselves as a mother of all children, a "mother earth."

Whatever reasons the applicant for a child gives, the fact remains that she is asking to become a foster mother as an expression of her womanliness and of her desire to mother a child.

Mrs. S applied to the agency for a child to board when her own two daughters were 11 and 13. The reason she gave was that since she had enjoyed caring for her daughters and could not have any more children, she desired the experience of foster care. After she received her first foster child she began requesting more and more children, and as the agency has come to know her better, her true motivation has become increasingly evident.

Because of a physical condition Mrs. S had been told by her doctor not to have more children. She followed his advice although this was in conflict with her religious beliefs. She has used the foster parenthood experience, the taking care of other children as a means of alleviating her guilt and of proving to herself that she can produce and mother children that she feels were denied to her.

Understanding Mrs. S's motives, the agency has been able to help her see more clearly her role as a foster mother. Recognizing that she has a need to give to many children, the agency has used her home for children that need her kind of giving—a giving that is not too deep but nonetheless gives the child the security of being wanted.

The following is a good example of the "mother earth" type of foster mother:

Mrs. B requested foster children when her own 10 children were grown and, most of them, had left home. She had never questioned her capacity as a mother and had thoroughly enjoyed her experiences. Her expressed and underlying motivation in applying for a child was that she missed having small children around and believed she could give a good home to a foster child. Also, she said, children made her feel young. She has approached foster parenthood with the same unquestioning attitude—a child is a child and she can be his mother while she has him. In recognizing Mrs. B's faith in herself and her continuing desire to be a mother, the agency has been able to give many kinds of children the positive experience of living with her. Since she has no desire for a child of her own, she is able to give excellent care on a temporary or emergency basis.

These examples illustrate how the identification of the foster mother's motivation can help the agency to place her in a role which will suit both her desires and the needs of the agency. However, the underlying motivation for foster parenthood is often veiled during the study procedure, as in the case of Mrs. S, and only becomes clear as a child is placed and the experience is lived.

Role of Foster Father

The foster father's role is one of far less visibility to the caseworker. And yet the foster father is constantly in the picture, even though in a less direct way, as far as involvement with the agency is concerned.

To begin with, the foster father defines to a considerable extent the role of the foster mother. The reverse is, of course, equally true. This principle is further reinforced by the fact that foster parenthood is not only relevant in relation to the child but that in some very essential ways it is also a problem of marriage.

While few data exist to prove this, it is probably true that the activeness, or passivity, of the husband in relation to the foster child greatly influences the way in which the foster mother perceives of her role. Since the foster child was placed with the family, rather than conceived by it, he is a child who only tentatively belongs there not only for mothering but also for fathering, and this may be more evident to the father. Moreover, in natural child production, while the wife "gives" a child to her husband, the activation agent of the gift is the husband whose positive self-image is enhanced by his ability and need to be a father, to "support" his family not only in the breadwinning sense but also in the sexual sense. Bringing a foster child into the home whom the father has not helped to produce may profoundly affect his image of himself as a father and a husband.

It has been our experience that foster families tend to be matriarchies, in which the rearing of children and the decision-making regarding their welfare is considerably more in the hands of the wife than of the husband. But even in such families one may not assume as a matter of foregone conclusion that this always satisfies the husband. While he may not do much about this, and while psychologically he may need an aggressive wife, the arrival of the foster child may awaken some internal but dormant conflict. Societal censure, implicit or explicit, may tend to strengthen his image of himself as a dependent man. And this is reinforced by the fact that it is the foster mother who provides care to the child more than the father. Additionally, there always exists the danger that the "pact" between the agency and the foster mother may intensify the man's inner conflict over his masculinity. In the eyes of the passive husband, the agency may easily become the "ally" of the wife and be perceived as a further threat to his masculinity. The agency has substituted for the father in giving a child to the foster mother. The wife in effect shows her husband that she is able to "have" a child without him. What may follow unless carefully discussed with *both* parents is anger, frustration, and a sense in the father of being "bypassed" by the appeal to an outside source for a child.

The foster father's motivation in joining his wife in an application for a child is not always clear. Often he simply defines it as a desire to make his wife happy.

In recent years much has been written about children who remain for long periods of time in foster

homes, children whose parents contribute little or nothing to their physical or emotional lives, children who belong to no one. Much criticism has been leveled at child-placing agencies for allowing these children to grow up without a sense of identity, with little or no security. This criticism has stimulated agencies to relook at the children under their care and the reasons for their being there. Emphasis is now being placed on making a definite diagnosis of the child's family situation at the time of intake with frequent reevaluations as part of planning for permanent care, either back with the child's own family or in adoptive placement. Thus for most children needing care, the ideal foster placement is now considered to be a temporary placement.

As we have already mentioned, a foster mother's request for a child is an expression of her womanliness and desire to mother a child, with possession and belonging implicit in this desire. This wish to have the child belong to her is in direct contradiction to the impermanence and sharing implicit in foster care, and means that a conflict exists between what she envisions as her role as a foster parent and what the agency has in mind for her. At our agency, we try from the very outset of the application to help the foster mother face the question of how her image of her role fits in with the needs of the agency. Is what she wants the same thing the agency has in mind for the child? We help her see that we appreciate her need to express her femininity through parenthood—in fact, this is one of the capacities for parenthood that we look for—but that the other part of this, her desire to have the child belong to her, is directly at odds with the goals of the agency.

Foster-Home Supervision

The agency defines the foster mother's role as a mothering person present in the child's life for a defined length of time; a person who can give him sustenance and security and from whom he can eventually be separated without trauma. The foster mother is helped to see how to act with the agency on behalf of the child, to give to him in the present without thought of the future. She is helped to see that she cannot "possess" the child, that, in fact, the nature of the foster-home experience makes this impossible, and that she must share the responsibility and planning for him with the agency. We try to help her to shift her idea of being a mother to a particular child to the idea of mothering children through the services of the agency.

A daytime foster mother with the two children for whom she provides care while their mothers are at work. Substitute mothers in a day-care program need the same qualities of flexibility and motherliness as do full-time foster mothers.

The supervision and development of a foster home begins not with the placement of the first child, but with the first contacts the applicants have with the agency. This is the home finder, the caseworker who makes the home study.

In many agencies the educative function of the foster-home study is passed over with a few remarks about agency policies, supplemented by the presentation of a manual to the new foster parents. When this is all that is done, the worker has missed an opportunity, and often the only opportunity, to begin building with the foster parents a firm foundation for their future relationship with the agency.

Most people making application to board children have little knowledge of social work, child placement agencies, or foster children, let alone a realistic conception of the foster parents' role. The educational function of the foster-home study, therefore, lies in three primary areas. First, the caseworker is responsible for introducing the applicant and her family to social work and what it means to work with a social worker. Secondly, he is responsible for introducing the family to the functions, policies, and procedures of his agency and its place in the community. Thirdly, he is responsible for introducing the family to the foster-parent frame of reference with particular emphasis on the foster-parent role.

The period of the home study is the only time the foster couple is alone in a relationship with the case-

worker. Therefore, this is the ideal time, not only for evaluating the quality of their family life, but for helping the couple to begin to fit their attitudes, experiences, and frames of reference into their new role as foster parents. Of course, the desire for a child will still be primary in the applicants' minds, and it is questionable how completely they can assimilate the new interpretations until they have actually lived as foster parents. However, the home finder's efforts at interpretation will give them the advantage of a foundation of understanding when they receive their first foster child.

Mr. and Mrs. J applied to the agency for a small boy, age 4. During the initial group foster-home orientation meeting, they expressed understanding of the agency's need for families who could serve many children over a period of time, as this was explained to the group. By the time of their first individual interview with the home finder, they had already begun to think about the kinds of children they might take rather than the kind of child they wanted. They had shifted their thinking from "the child for them" to a child who would need them. Before the home study was completed, they had moved from their original concept of taking a little boy to "be like their own" to a willingness to accept any foster child between the ages of 2 and 8 who might need them.

A little girl, age 9, was placed with this family and they accepted her with warmth and understanding. About a year later she was returned to her mother and although it was very difficult for the foster parents to see her go, they understood what she had been saying to them in words and action—that she needed and wanted her mother. Since this first placement, Mr. and Mrs. J have accepted children from toddler age up to 10 years of age. Through their numerous experiences they have truly realized the concept of being foster parents to children.

All is not so ideal and agencies do make mistakes and compromises, as our agency did with Mrs. M.

Mrs. M requested a little girl about the age of her own daughter who was 7. The foster-home study showed that Mrs. M was a rather unhappy person, dissatisfied with many aspects of her life. She questioned her capacity to mother and found some dissatisfactions, as well as many satisfactions, in her own child. The positive factor was that she reached out for children and obviously enjoyed contact with them.

Mrs. M stuck to her request for a small girl, and eventually one, age 5, was placed with her. She immediately identified with this child and obviously found many satisfactions in her she had not found in her own child. Her words and actions implied that the child belonged to her alone and not to her husband. Trouble began when the natural parents entered the picture. In spite of the worker's efforts to interpret the inevitability of this and support the foster mother in a sharing role, she could not accept this and asked for the child to be removed.

Thus, apparently some people can move into the foster-parent role and others cannot. Sometimes the failures are due to misevaluation of the foster parent's potential for doing this, but sometimes they are due to the fact that the living of foster parenthood is difficult to conceptualize and anticipate on the part of the foster parent and caseworker alike. Some fruitful research has already been done in regard to ways of determining foster parenthood capacity,[4] but this is still an area in which we need more knowledge and understanding.

In the continuing supervision of foster homes, the caseworker works from the same concepts as already described.

When a child is offered to a family for the first time, the foster mother is faced with the prospect of putting into practice her new-found role and of experiencing in actual day-to-day living the conflicts of foster parenthood. She must be a substitute mother giving love, interest, care, investment of her self while sharing the child with others, knowing he can never be fully hers. The caseworker can best help her by recognizing her as a individual living with a conflict she can never completely resolve even with the caseworker's help, since the agency cannot give her the child she desires.

Caseworkers often feel that the first separation from a child makes or breaks a foster mother as a foster parent, as it did Mrs. M. All of our words do not and cannot do what a living experience can do. Often the only first separation can teach the foster mother the real meaning of the partial, temporary, and sharing aspects of foster parenthood.

However, caseworkers can make the job of foster parents—fathers as well as mothers—easier for them by understanding and helping them to handle their feelings in regard to their foster child and the limitations of foster parenthood.

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Our civilization is doomed if the unheard-of actions of our younger generations are allowed to continue. They are rowdy and disrespectful and they stay up late at night.

From an ancient tablet unearthed at an excavation site in Ur; quoted by Arthur Roth in The Teen-age Years, *Doubleday Co., 1960.*

In an attempt to strengthen staff use of mental health principles . . .

A PSYCHIATRIST PARTICIPATES IN A COUNTY HEALTH PROGRAM

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PROBLEMS associated with mental health and illness have long confronted the public health field without being recognized definitively as a major responsibility of public health agencies. However, since World War II local health departments have increasingly sought to determine their responsibility for maintaining mental health. Some departments have established mental health clinics or after-care services; others are seeking a way to add mental health dimensions to existing programs.[1,2] Among the latter is the Tyler-Smith County Health Department in Tyler, Tex.

Located in an urban-rural county of 86,000 inhabitants, this health department 2 years ago introduced psychiatric consultation in an effort to integrate mental health principles and methods into its program. The focus has been on the nursing services, but the project has also drawn in the local physicians participating in clinics and well-child conferences. Ultimately, its effects are expected to reach out to other areas of health department functioning.

In addition to the health department, Smith County's health and welfare services include a county child welfare unit, a local office of the State department of public welfare (categorical assistance), a one-worker county welfare department (general assistance), a juvenile probation department, and a mental health association with a full-time executive. There are also school counselors and visiting teachers, a vocational rehabilitation counselor, and four psychiatrists in private practice.

The health department includes on its staff 2 full-time doctors, 9 full-time nurses, and 17 part-time clinicians, as well as sanitarians and auxiliary personnel. Six of the nurses have had at least 6 months' specialized academic preparation beyond their R.N. training. The nursing staff renders a generalized nursing service to the entire county, including work in school health programs in rural schools, community immunization clinics, crippled children clinics, maternal and well-child conferences, and home visiting for direct nursing or followup of any of these programs.

The chief spark to the department's mental health project was the nurses' interest in learning how they might work better with their patients whose physical ills are so often complicated by emotional problems and difficulties in personal, family, and social adjustment. Therefore, its main emphasis has been on helping the public health nurses find answers to the many questions which were puzzling them. For example, how can the nurse "reach" the mother who says she wants to attend well-child conference sessions but repeatedly breaks appointments? Or, how can the nurse motivate parents unwilling to exercise their child's clubfoot, or to keep his splints on at night "because he cries"?

In staff discussions of the frustrations of their

jobs, the nurses had expressed a desire to improve their interviewing techniques and to learn to use anticipatory guidance in all phases of their nurse-patient relationship. These goals, it became clear, called for an inservice education program based on problems and situations arising in day-to-day public health nursing practice, and drawing on the special insights of a mental health professional to augment the resources of pediatricians, obstetricians, and other clinicians who staff the various clinics and conferences.

With this impetus, the local health department secured funds from the mental health division of the State department of health for the services of a local psychiatrist to set up and operate such a program. The State mental health division also provided periodic field consultation in the program's planning and developmental stages.

Rationale of the Project

Planning proceeded on the theory that increased understanding of the dynamics of behavior—including the interactions of the nurse-patient, nurse-doctor, and doctor-patient relationships—would enable the nursing staff to function more effectively; that this would be observable in strengthened rapport between the staff and patients and more acute awareness of patients' nonverbal communications; and in improved interviewing as well as more comprehensive service to the patient and his family. This increased effectiveness, it was believed, would be especially valuable in the maternal and well-child conferences for promoting improved emotional growth and development of children.

From the beginning, it was decided that the psychiatrist was *not* to give direct diagnostic or treatment services to patients, but was, rather, to act as consultant to the nursing and clinical staff. The essential purpose of her contributions would be to help the nurses and doctors do their own jobs more satisfactorily by the more telling use of their individual abilities and the practical application of psychiatric theory.

Presentation of formal theory was kept at a minimum, but psychiatric insights were brought into focus as situations arose to make them meaningful within the framework of normal nursing or clinical functioning. For example, the nurses could learn—without plunging into detailed psychoanalytic theory—that listening for the feelings attached to what a person is saying can make it possible to understand and facilitate the gratification of his unvoiced emotional needs. Occasional explanations of concepts were anticipated as necessary in order to put together observed pieces of present-day knowledge of child development, parent-child relationships, and patient-nurse-doctor interactions.

It was anticipated that the psychiatrist would meet with nurses individually and as a staff, and that she would observe and participate in clinic procedures and postclinic conferences with nurses and clinicians. Further planning for the use of her services was left flexible to accommodate needs.

Orientation

The psychiatrist spent her first month on the project observing the nurses' and clinicians' roles, responsibilities, and routines. She attended the clinics and visited homes with the nurses to reorient herself to the public health milieu and to get the "feel" of family patterns and problems in the health department's clientele. She also initiated six 1-hour seminars for the nursing staff—on emotional growth and development, and structure, ingredients, development and characteristics of personality.

These seminars were followed by a 2-day workshop on "Applying Mental Health Principles in Public Health Nursing." Participating with the psychiatrist as resource people in this stage-setting workshop were mental health and nursing consultants from the State department of health.

In helping to plan the workshop, the nurses identified goals directed toward personal growth and professional growth. The goals for personal growth included: a better understanding of how to work with people; more knowledge about why people react to situations as they do; and learning not to show personal reactions and feelings at inappropriate times. The professional goals identified were: learning to accept reality situations with objectivity, to give what help is possible and to increase it where needed, to improve interviewing skills, and to be more considerate of other people and their problems.

The objectives of the workshop were: (1) to encourage the nurses to substitute empathy for sympathy in work with patients; (2) to develop within the limits of public health nursing skills, improved handling of patients with emotional or mental problems; and (3) to provide the individual nurse with support and self-understanding when needed.

In the workshop the nurses presented case examples of mental health problems they had observed in their patients. These case presentations and the subsequent discussion revealed attitudes both of

overidealization and resistance to psychiatry as well as other more objective insights. Anticipation of criticism of their work apparently evoked in the nurses some feelings of insecurity and anxiety. However, when instead of criticism, they encountered understanding, acceptance, and support, they relaxed and offered their own observations and evaluations of cases more freely. At times the nurses expressed feelings of overwhelming helplessness and frustration in regard to the mental health problem under discussion. These expressions were met with discussion of the obstacles to ideal mental health services in the community and with encouragement to learn to accept feelings of frustration.

The workshop clearly revealed the need for greater objectivity on the part of nurses in handling patients and for increased skill in applying the mental health principles they already knew. There was evident, however, a unanimous desire to learn to work more effectively with patients, for everybody participated in the discussion and offered suggestions not only in regard to the handling of individual cases but also in formulating goals for the mental health program.

Thus during the first month of the program, the public health nurses, their nursing supervisor, the psychiatrist, and the outside consultants began to learn together some of the implications of a mental health approach to their professional roles as well as to agency functioning. The first awkwardness of the period when the program was on trial with the staff was quickly overcome.

On the Job

Following the orientation period, a schedule was devised to enable the psychiatric consultant to spend 17 hours a month working with nurses and clinicians. The schedule included: 6 hours in individual conferences with nurses about specific patients or problems in working with them; 1 hour for a conference with the total nursing staff, with didactic presentation of theory, case presentations, and evaluative discussions; and 11 hours in observation and participation in maternal and well-child conferences.

The theoretical framework underlying the program may be described as eclectic. Lectures on personality growth and development and some of the clinical teaching are based on psychoanalytical theories. Psychodynamic interpretation has been prominent as well as the concept of the effect of emotional stress on the body. Particular attention has been given to problems of interpersonal relationships and how to deal with them. The psychiatrist's methods of instruction evolved from her own on-the-job observations and the experience of others.[1, 2-5]

Individual conferences between the psychiatrist and nurses have the purpose of providing the nurse with a feeling of support, of recognizing and dealing with personal problems affecting the individual's work, and of offering each nurse a private opportunity to learn how to improve her handling of difficult cases or interstaff relationships. The nurses determine the subjects to be discussed. Rarely has there been a lack of material.

In the staff conferences the lectures have focused on personality growth and development, the major psychoses, and related subjects, sometimes with the use of films followed by group discussion. The case presentations are made and selected by individual nurses with the view of securing help not only from the psychiatrist but also from the group. The evaluative sessions have dealt both with the evolving mental health program and with group evaluation of problem cases.

One case presented in staff conference concerned a mother who had been in an iron lung for several years and had been recommended for psychiatric help but had not received it. Following the staff discussion of this case, the nurse who presented it was able to help the family to get the patient into a rehabilitation hospital for health supervision, both physical and emotional, and to help the family in other ways.

In addition to the nurses, the director of the health department sometimes attends the staff conference as do invited guests from other agencies—the social worker at the nearby tuberculosis hospital or a special education teacher from the public school system.

MCH Conferences

In participating in maternal and well-child conferences, the psychiatrist has found four types of consultative opportunities:

1. ***Observing preconference interviews*** makes it possible to note each nurse's individual way of getting along with the patient (or parent and child) and to suggest other possible approaches, either immediately after the patient has left, during the postclinic conference, or in private conference with the nurse. If the nurse does not feel the need for consultation, she is not "pushed" into it. The freedom with which the nurses have made use of the opportunity for consultation is indicative of their feelings of security. The psychiatrist always attempts to enhance this feeling.

2. ***Occasional group sessions with mothers*** conducted by the nurses provide an opportunity for the psychiatrist to help the nurse develop skills in working with individuals in groups. In these informal groups, the nurse finds herself in a situation where modes of behavior and interaction are often quite different from what they are in individual interviews or during a clinical examination. With the focus on such recurrent topics as children's behavior problems, discipline, eating problems, sleep disturbance, bed wetting, and how parents should deal with them, the nurse attempts: (1) to dispense information; (2) to give group and individual support to members; (3) to exert group pressures for change; and (4) to increase understanding and use of mental health principles.

The psychiatrist attends these sessions as a resource person for the nurse-leader, and afterwards serves as a consultant with the entire well-child conference staff—including nurses and doctors—in a review of what occurred.

3. ***In accompanying the patient during the physical examinations,*** the psychiatrist helps each staff member do a more thorough job at his own station and to integrate results of his particular area of contact with those of the next worker.

For example, a 3-year-old struggles furiously against submitting to the physical examination. The mother, embarrassed, slaps and sharply reprimands her child. The psychiatrist talks with the mother, helping her, and the staff as well, to feel more comfortable and to accept the child's behavior.

4. ***Postclinic conferences*** have been found to provide the most consistently significant learning experiences for the participants—three staff nurses, two student nurses, a clinician, and the psychiatrist. Case material is fresh; the observations of each participant may be compared before they are forgotten, and new meanings in patients' comments or reactions may be discovered. Through these conferences, the nurse responsible for followup can probe into her colleagues' impressions and judgments on various facets of the problems presented as she formulates the approach she will use when next visiting the family.

In structure, the postclinic conference is nonauthoritarian, the psychiatrist functioning as a group member as much as she does as leader. Responsibility is placed on the nurses and clinicians jointly to provide the material for discussion. The psychiatrist often asks questions intended to provoke discussion, and answers one question with another—but where specific psychiatric information will be useful, gives this directly.

If the participants feel secure enough for free discussion, the group members may comment on an individual participant's way of relating to the patient and give suggestions for meeting unexpected situations. They may discuss the question of whether time was used effectively in relation to the patients' needs rather than according to the nurse's or clinician's desire to follow familiar routine. They may also suggest ways of helping mothers to cope with problems connected with phases of emotional growth and development such as feeding and weaning difficulties, toilet training, thumbsucking, temper tantrums, bed wetting, and their own feelings of rejection. The psychiatrist repeatedly stresses the fact that skillful ability to listen is an invaluable tool for the professional person, which can result in great benefit to the patient.

Behavior problems, excessive anxiety, and personality traits of mothers and children observed in clinics have been discussed in these postclinic conferences, with the result that both nurses and clinicians are beginning to be more aware of variations among patients. They have revealed an increased ability to think through the dynamics of behavior and to search for adequate means of helping the patient.

In these conferences the psychiatrist often points out signs revealed in the clinic session of a patient's abnormal emotional or mental functioning or of normal variations of defense patterns, cultural differences, and personality characteristics. The purpose is to increase the nurses' and clinicians' ability to distinguish between normal, neurotic, or psychotic adjustment, and to determine which patients they can assist directly and which need referral elsewhere for treatment or other service.

As the conferences have progressed, an initial anxiety on the part of clinicians in regard to them—and the psychiatrist's role in them—has obviously decreased. The clinicians have begun to participate more, making contributions from their particular fields of medicine and pooling their experience and ideas in regard to mental health with that of the other participants.

Some Values

Through the process of sharing in postclinic conferences, nurse, psychiatrist, and clinician have come to new understanding of each others' skills, insights, functions—and limitations. Several times the overidealization of the physician's role has been evident,

and the common idea of the physician's "omnipotence" discussed. The clinicians have asked questions, made suggestions, and at times given evidence of some changes in their ideas or attitudes.

For example, during one postclinic conference it became apparent that the nurses resented the fact that the clinician seldom reviewed the patients' records or read the nurses' preconference notes. After this was discussed openly—for the first time—this clinician and the nurses were able to work together more effectively.

These postclinic conferences and other group situations in which interpersonal relations, interreactions, and communications problems are discussed freely have resulted in increasingly harmonious and effective staff relationships. The staff has exhibited a growing tendency to work out more satisfactory adjustments of inevitable differences.

Personality difficulties of the participants have occasionally emerged in staff group discussions. As yet, these have not been openly discussed in the group, but are dealt with indirectly or in a private conference. The individual conferences between nurse and psychiatrist also provide an opportunity for working through other individual blocks to optimum performance on the job.

One of the most needed changes in the nurses' attitudes has been to become realistic about limitations inherent in the public health nursing role. We believe that the program has achieved some success in this direction. As nurses have come to see why some patients cannot make better use of their service, they have substituted more realistic goals for overoptimistic ones. The psychic energy which was tied up in frustration over unrealistic efforts has then been released for use in more productive directions. For example, some nurses tend to keep cases open which might as well be closed because of the patient's or parent's lack of interest. When such a case is finally closed, the nurse can direct more time and attention to other patients.

We have learned that the nursing staff has had in reserve much awareness of the emotional problems of the patients with whom they have worked as well as a great deal of empathy with them. At the same time, however, they have hesitated to talk about these problems with their patients. The program has encouraged them to develop their empathy to the fullest and has given them support in bringing out in the open with the patient by question or comment the sensed areas of maladjustment, conflict, and anxiety. Most of the nurses have gradually come to see that in office interviews and home visits a considerable amount of their time can be profitably spent in exploring the mental and emotional health of the patient without detracting from the nurse's traditional concern for his physical health. In varying degrees and at different speeds, the nurses have become more comfortable in taking up with parents, at the appropriate time for the individual, problems connected with phases of emotional growth in children.

Briefly, the program seems so far to have produced the following results among the nursing staff:

1. Inclusion of mental health awareness in all areas of work.
2. Greater knowledge of the dynamics of human behavior and emotions.
3. An increasing awareness of the subtleties in interpersonal relationships and use of this sensitivity in working with patients.
4. A reassuring sense of confidence in working with patients in areas involving feelings.

In spite of some initial anxieties connected with the great deal of staff time spent in planning and the shifts in schedules required, no recognizable hostility has been observed or verbalized toward the program. Although some administrative snarls have occurred, there have been no apparent serious emotional snarls. It is, of course, impossible at this early stage to give objective evidence to substantiate feelings regarding the program's success.

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CASE CONFERENCES IN A FAMILY CENTER

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THE WORDS "case conference" hold a variety of meanings to many professional and lay people. Hospitals, schools, social agencies, health agencies, and probation departments hold case conferences in some fashion or other. Their general purpose is: to clarify and diagnose a problem, to transmit information to everyone involved with the problem, and to plan a course of action together to solve or in some way minimize the problem.

Case conferences have become almost routine with social agencies, whose staff members need to confer together periodically for planning how to deal with all the troubles, fears, and problems that their clients bring to them daily. And when many agencies are dealing with the same client, the agencies need to get together for the same purpose.

At the Huntington Family Centers of Syracuse, case conferences are an important part of the procedure in serving families and children. Huntington, a Community Chest-supported agency, operates two family centers in Syracuse. Both are located in deprived areas of the city and have identical functions and policies. The activities described in this article will be those of the East Side center, which provides casework and group-work services to 120 families in its immediate neighborhood, and group-work services to 80 additional children whose parents are not in the program.

Most of the families coming to the center have many problems. The focus is on comprehensive treatment of the whole family by the use of casework, group work, and community organization. The policy has been to reach out to young families, or other families with young children, where emphasis can be placed upon prevention rather than correction. The agency's aim is to try to help the family by strengthening family ties, preventing breakup, and promoting self-sufficiency in all members of the family.

A variety of programs have been designed in order to accomplish this purpose. First, there are the *homemaking groups* for mothers, conducted by a professional social worker who has specialized in group work. Then, there is a *nursery school*, led by a person trained and skilled in nursery education. These two programs operate concurrently in the early afternoon, three times a week. Next come the *after-school groups* for children 5 to 14 years of age. These groups are small and are led by volunteers, each responsible to and supervised by the group-work supervisor and his assistant, both also social workers who have specialized in group work. Individuals or families who are part of these groups are referred for *casework service*, when this seems called for, to the center's social caseworker. Casework treatment is provided on an intensive basis with one or more contacts per week.

The agency also operates a *clothing exchange* once a week, holds a *family supper* once a month in which all families are invited to participate, and holds *parent-education groups*. It also runs a *family camp* attended by a carefully selected group of families for whom the experience is regarded as a part of the treatment plan.

The reader can readily see that the staff members of the agency see the families from various angles and that close cooperation among them is necessary for a picture to emerge which will depict the family as a whole. This is accomplished during the weekly *case conferences*.

The following incident illustrates how a misconception can be dispelled when staff members work together.

The director and the caseworker were discussing a family that had attended the monthly family supper. The director commented on the fact that the father seemed to hide behind the dark glasses he was wearing. The caseworker, who had been to the home

earlier, told him that actually he was not hiding, but had broken his regular glasses and had to wear his prescription sunglasses instead. However, she said she felt that the father had acted with authority and protectiveness in selecting the head table and placing all his family around him. The director changed that idea by telling her that he, himself, had placed the family there.

This example shows how easy it is, even for professional workers, to jump to a conclusion, or have a biased opinion based upon very meager evidence. It also shows the necessity for close cooperation between all persons who deal with a family.

While there is a regular period for case conferences at Huntington, a conference can be called at any time during the week in an emergency. In any event, every staff member is presented at the conference and knows well ahead of time—usually at the end of the last conference—which cases are to be discussed. Usually two to three cases are covered during a 2-hour conference. The procedures are informal. As a rule the staff member who has had the closest contact with one of the family members—a child, a mother, a father—presents the case. Then each staff member gives his observations on the family. Following this, there is a general discussion which leads to an agreement on a plan of action. The group then decides if and when the case should be reviewed again.

The Bowers Family

For example, there was the conference on the Bowers family.

Mrs. Bowers, now 44 years old, had come from the rural South many years ago and had managed thereafter to achieve 2 years of a college education. She then met Mr. Bowers and married him. She learned later that he had been married before, and since no divorce had been obtained that her marriage was not legal; but she was not aware of this fact until after Mr. Bowers died in 1957. The couple had four children; Miriam, 11 years old; Charlie, 8 years old; Penny, 6 years old; and John, 5 years old.

The Bowers family has been participating in the Huntington program for about 3 years. The two oldest children came first to the group-work program. Then the mother joined a homemaking group and at that time brought Penny and John to the nursery.

During the summer of 1961, a change was noticeable in the Bowers family. The mother seemed more distraught. Charlie began acting up in his group, and Penny, who is a very stout little girl, demanded more attention and food in the nursery. The mother and the children were invited to attend the family camp. There the camp staff noticed that although the children seemed to be enjoying themselves the mother was preoccupied and under stress.

Until this time, Mrs. Bowers had been self-supporting, working as a cleaning woman, but shortly after she returned from camp she discovered she had high blood pressure and a slight heart ailment and could not continue in this heavy work. Therefore, she quit her job and applied for public assistance. When this happened, the agency decided to hold a case conference on the Bowers family. As Mrs. Bowers had requested some specific help around her financial problems, the caseworker called on her prior to the case conference to discuss these problems with her and to make a more systematic evaluation of the home.

The entire staff was present at the case conference, plus two graduate students of social work who were serving their field-work placement with Huntington. Having had the closest contact with the Bowers family, the family group worker made the presentation, which was supplemented by the caseworker with information she had gathered during her visit, and by the workers who knew the children in the nursery school and after-school program.

The family group worker described the mother as she had known her for the past 3 years, her participation in the homemaking groups, her attendance at the parent-education groups, and her stay at the

Some months ago, CHILDREN inaugurated a Case Conference feature to appear intermittently in the journal. The first "conference," which appeared in the May–June 1961 issue, was composed of a case story of a family with a variety of neglected health and family problems, and the comments of four persons, each of a different profession, to which the story had been submitted with the query: "Whose responsibility was it to see that this family received the appropriate service?"

As the result of this feature, the journal received a request to publish a report of an intra-agency case conference as it had actually been handled within one agency. The accompanying article is CHILDREN's answer to this request.

Readers are invited to contribute to the discussion of the Bowers' case, contained within this article, or of the article as a whole, through the "Readers' Exchange" section of subsequent issues of this journal.

camp. There emerged a picture of a woman whose attendance was good, who was serious about the job or the discussion at hand, who wanted to be respected by her immediate community as well as the larger community around her. The nursery school teacher substantiated this account by recalling that Mrs. Bowers was active in the PTA as well as her church.

During the ensuing discussion, however, it became clear that there was a self-defeating strain in Mrs. Bowers. Her standards and aspirations were high and definitely middle class. She was putting real pressure on her children to conform to these standards. However, she, herself, had difficulty in maintaining them.

Mrs. Bowers had never acknowledged the fact that her husband was previously married and that, therefore, her marriage was not legal. We had learned this fact from the Department of Public Welfare. She had made clear to us that she found it extremely difficult to accept public assistance, but despite her educational attainments she had done nothing to find a job that was less physically demanding than the janitor's job she had had to leave. Moreover, we had learned through the Department of Public Welfare that during her illness, which occurred 2 years after the death of her husband, she had had a miscarriage.

We knew from chance remarks of her older children that Mrs. Bowers was allowing men to come into her home and to stay very late at night. At the same time, she expressed concern about whom Miriam, the 11-year-old, associated with and about what she did at all times. When Mrs. Bowers was at the center with her children, she watched constantly to see that they behaved well—in other words, that they were quiet, clean, and did not quarrel among themselves or with other children. There was, however, a discrepancy between the children's personal appearance and the appearance of the home. The children were better dressed than most others coming to the agency. However, the family group worker in visiting the home often found the apartment in complete chaos—piles of dishes in the sink, laundry strewn about, and no evidence of any attempt having been made at sweeping or dusting.

Here then was a woman who was torn between the desire to raise her children and live according to middle-class standards and her knowledge that she was violating some of the rules of middle-class society. In some manner she must also have been aware of the fact that this discrepancy was apparent to her children, but because of her need to keep up appearances to the outside world, her pressures upon them to conform continued.

The group worker reported that Charlie was beginning to show more aggressive acting out of his inner problems and some signs of confusion about his own identity and ability. The nursery school teacher told us that Penny was no longer the happy, self-sufficient child in the nursery but had become more dependent and withdrawn.

We came to the following conclusions: Mrs. Bowers with the help of Mr. Bowers had managed well in raising her family, imbuing them with a sense of responsibility and independence. When he died she continued for a while to hold on to the values that she considered important. Little by little, however, she relinquished some of them and the resultant guilt feelings began to have an effect on her relationship to her children and hence on her children.

How much all this affected her physical health we could not tell, but we felt that it most probably had something to do with the heart illness she suffered in the summer of 1961.

Our next question during the conference was, of course, *what now?* How can we at Huntington be of best service to this family? Should we concentrate on the children and help them by way of our group-work services to make adequate adjustment in their life situation? Should we offer casework services to Mrs. Bowers, who as yet has not asked for this kind of help?

The group-work supervisor thought that Mrs. Bowers should be immediately faced with her problems as we saw them. He suggested that the family group worker, being closest to Mrs. Bowers, should tell her frankly what she was doing to her children by keeping this double standard, this pretense of being an upright, morally decent, self-respecting woman, without actually following the standards herself. He felt that this should be done for the sake of the children, because, as he saw it, Mrs. Bowers would become more and more disturbed in trying to keep up a middle-class façade without having sufficient inner strength to do so and without the support of reality. The children, after all, could see what was going on at home. On the other hand, the family group worker and the caseworker suggested that deflating Mrs. Bowers' middle-class self-image would be taking away the most important props and defenses that she had at this time, and that we had nothing at hand to substitute for them. Everyone agreed that we could not be very effective with the children unless we also helped the mother.

We finally decided that we could be of most help to Mrs. Bowers if we continued to support her by accepting her and her family as we had done all along. However, until now we had treated Mrs. Bowers as if she really were a strong person in her group at Huntington and in the outside community. Now our focus had to be shifted slightly.

The ground for this, we decided, would have to be prepared by the family group worker. Through discussion in the homemaking groups and in individual interviews, the group worker could help Mrs. Bowers to see that the type of problem she was struggling with—such as wanting to be respected, and raising her children properly while being involved with a man to whom she was not married—was not unique; that there were many other women in the group with similar problems. Through group discussion, Mrs. Bowers could also learn that accepting the help of a caseworker need not mean that she is a weak, incompetent person. In fact, she might emerge as a stronger and more effective mother and member of the community if she could understand herself better and learn to handle her problems in a more realistic manner. Thus Mrs. Bowers could be helped to see that seeking casework service would not be depriving her of her independence.

We knew that she trusted us and thought highly of us. We felt that this plan would succeed because she had an especially good relationship with the family group worker, and her attendance at homemaking groups had continued to be regular. At the same time, we planned to give greater attention to the children.

We also decided at the conference that our agency would offer to become the coordinator of the various community resources available to the Bowers—the Department of Public Welfare, which was giving the family an assistance grant, the Syracuse Dispensary where Mrs. Bowers was being treated for her heart ailment, and the schools where the children were enrolled. Mrs. Bowers had been wanting to move because of the physical demands that her home made of her. Our subsequent contact with the welfare department in which we were able to explain some of Mrs. Bowers' difficulties was sympathetically received and followed by action which enabled the family to move to an apartment that was more convenient and required less work and upkeep.

As a result of the case conference on the Bowers family, the staff learned the needs of the *total* family. Prior to the conference, each staff member in touch with a member of the Bowers' family had treated that person in isolation. Now it could be done as part of a concentrated effort. The next step then was to put our plan into action, and then after 3 months to meet again to see what progress had been made.

These things we did. At the followup conference we noted the following facts:

The older children's behavior had changed little, if at all. The youngest child seemed less anxious but perhaps even a little more aggressive than before. The biggest change had occurred in Mrs. Bowers. She had begun to understand a little how her problems affected her children. On several occasions she had come to ask for specific help from the caseworker, and finally within the last month she and the caseworker had sat down together and had considered what casework help could mean to her. She had then decided to use this service, plus continuing her regular attendance at the homemaking group.

The staff was satisfied. Even though the program was slow, it was having positive effects.

Some Principles

As with most cases discussed in a conference, the Bowers' case was selected a week prior to the actual conference to give the family group worker and others enough time to organize their material. We have found this procedure quite useful, as it eliminates the necessity of writing a formal case presentation. As the various staff members contribute their material, the caseworker takes notes which are then used as the basis of a short report prepared after the conference.

All families registered with the Huntington Family Centers are the subjects of case conferences at least once a year. Many have a second review after 3 months as did the Bowers family. Of course, if a crisis arises, a case conference can be held immediately. Since our focus is family centered, the total family is considered in each conference even though the precipitating problem may seem to involve only one member.

It is not always easy to keep a conference centered on the family under discussion. Many a time we have gone astray and found ourselves involved in some technical or theoretical problem that has had little or no relation to the case at hand. This was interesting and even educational, but of little value to the family under discussion. We, therefore, try hard to avoid such digressions.

One of the values of a good case conference that has not often been recognized is the help that the staff members give to each other during such a pres-

entation. For instance, during the Bowers' conference, the nursery teacher who had become increasingly troubled by Penny's behavior was made aware of the various pressures that surrounded the child at home. This made it easier for her to understand the child's behavior in the nursery and to deal with it. As the staff members present their views of the family, the total staff knowledge is enlarged and all can be strengthened by this.

Throughout our discussions of the Bowers family there was the underlying assumption that the family could be helped through the services that Huntington has at its disposal. A case conference can be completely fruitless if this is not the case. Every member of the conference must be aware of the help that the agency can provide. If the case under discussion requires different tools than the agency has at hand, this should be recognized immediately. Otherwise, a great deal of time can be spent on useless, even though diagnostically sound, behavior descriptions.

For example, at another conference held at Huntington we discussed a family consisting of a man and his wife and six children, who had recently been referred to the agency. This family was beset with tremendous health and financial problems which overshadowed every other aspect of the home. The staff spent considerable time in talking about the strengths and weaknesses of the various family members. The behavior of the parents was described and consideration given to the psychological impact this had on the children. When we were finished with this and set out to make a plan of action, it soon became apparent that our agency was not equipped to help the family until their major problems were met. What this family needed now was the help of the Department of Public Welfare and the Department of Health. If we had recognized this at the start, we could have saved ourselves and the client, a considerable amount of valuable time.

Whether the conference is an intake, an interagency, or an intra-agency conference, every participant must know what services can or cannot be offered and what the client can or cannot achieve with the help of these services. We have all sat in conferences where this factor was not taken into account, with resultant frustration for everyone concerned and a great deal of "passing the buck," either from one staff member to another or from one agency to another. In the meanwhile, the client and his problem recede into the background without receiving any effective help.

To summarize, at the Huntington Family Centers we have found case conferences most effective if they are conducted in the following way:

The conference is held in an informal atmosphere with all staff members participating. Cases for discussion are selected well in advance, priority being given to those facing crises. The focus is on the total family. Usually not more than an hour is spent on discussing one case. One staff member presents the case and the rest add what information they have about the family. The staff then arrives at a diagnosis and a plan of action is formulated. Notes taken during the conference are compiled and a short report is made.

If we feel that our agency is not equipped to handle a certain problem, we seek to find another agency that can do so, stating frankly that our agency cannot work with this problem and giving our reasons for coming to this decision. We have found that in this way we have streamlined the conferences and have been of greater service to our clients.

Any long-range attack on dependency requires that we understand better than we now do how we may help children in ADC and similar homes more adequately prepare for adult roles. As we all know, we have a particularly critical problem in a society that continues to move in a direction that makes a vast group of young people expendable so far as the labor market is concerned. It is estimated that there are nearly 1 million unemployed youth in the age group 16 to 25. How many of these will swell the ranks of deserting or putative fathers?

John M. Romanyshyn, professor of sociology, University of Maine, to the 1962 forum of the National Conference on Social Welfare.

An essay review . . .

A RELOOK AT THE EFFECTS OF MATERNAL DEPRIVATION

MILTON J. E. SENN, M.D.
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VERY FEW publications in the field of research about human behavior have excited as many people as the monograph by John Bowlby,[1] dealing with maternal care and the mental health of children, published by the World Health Organization in 1951. Now with the publication of a new monograph, "Deprivation of Maternal Care—a Reassessment of Its Effects," * WHO has provided an opportunity to review the theories presented by Bowlby in the light of 11 years of perspective and the findings of new research.

A year or so before the publication of his 1951 report, Bowlby came to New Haven to talk with me about research in infant development which the late Katherine Wolf and others were doing at Yale University. He was aware of studies on the relationship of faulty infant development and maternal deprivation made by a few Americans, especially René Spitz, but he had not been informed of the carefully done followup studies of William Goldfarb, which then were recognized as extremely important but against which there already had appeared criticisms of the kind and severity which later were to be leveled against the Bowlby review.

Bowlby's intent was to gather the strongest evidence he could to prove to persons in the child care field that the quality of the psychological milieu in which infants are reared had decisive influence in shaping their personalities, and that the rights of infants included parental nurture of a highly personal variety. The effects of his painstaking study were immediately evident. Child welfare workers, along with psychiatrists and some pediatricians, began to appraise every type of institution caring for infants in relation to its ability to provide babies with all the things they needed as growing and developing human beings. Important changes were made in some of them.

For example, staffs of hospitals for children reviewed their visiting hour schedules for parents, frequently concluding that flexibility of scheduling not only promoted a healthier and happier relationship between the child, his parents, and the hospital personnel and prevented after-care anxiety, but also reduced some of the congestion and confusion of the visiting period. Social welfare workers set up new standards of optimum care, and when domiciliary institutions were unable to meet these higher standards their administrators were advised to close their doors.

Foster family homes began to be considered much more suitable than congregate care. In some places there was an extreme shift from institutional care to the use of foster family placement, completely excluding the larger institutions for children who could not be cared for by their own parents. With time, the error of this uncritical change has become apparent, and the belief is no longer so widely held that a foster home always is a "home," and that every large

*Prugh, Dane G.; Harlow, Robert G.; Andry, R. G.; Mead, Margaret; Wootton, Barbara; Lebovici, S.; Ainsworth, Mary D.: Deprivation of maternal care—a reassessment of its effects. WHO Public Health Paper No. 14. Columbia University Press, International Documents Service, New York, 1962. 165 pp. $2.25.

establishment is barren of intimate human experience because of its size. Realists among the everyday workers with infants have discovered that size per se is not the best gauge of suitability, and have concluded with Bowlby that the quality of care must also be examined more critically before hard-and-fast rules about proper care of babies bereft of rearing within their natural homes could be established.

It is not known how much of the Bowlby report has been read by Russians who work with children. They, of course, credit the theories on which they have based their extensive programs of child rearing outside the natural family solely to Russian patriots, especially Lenin, Pavlov, and Makarenko. However parochial that might be, the Russians have demonstrated how to provide children in residence with group-living experiences of many kinds which seem highly satisfactory in promoting the most favorable physical and social development. The foster family home is unknown in Russia, but the Russians can present good evidence for their belief that institutional care can achieve intimacy in interpersonal relations between surrogate parents and infants.

Criticism and Reassessment

The greatest criticism of the Bowlby report has come from scientists who have questioned the interpretations of the data and suggested a reassessment of them by more rigorous statistical analysis.

In view of the variety of criticisms in the past 10 years, many persons have attempted to review the problem of maternal deprivation in a wider perspective, and frequently have been stimulated to carry out new research to validate or disprove the conclusions which appeared in the Bowlby monograph. Bowlby and some of his colleagues at the Tavistock Clinic in London have been among those not content to let matters rest, and have sought to redefine their theories of how infants develop normally, and how they may be affected by such experiences as deprivation of mothering.

The World Health Organization has been aware of its own obligations, especially to workers in the developing countries who are attempting to set up optimum child-care resources for infants and children, to reassess the material presented in its publication, and to attempt to take the issues out of the area of controversy. In its customary fashion of careful and objective assessment, it invited a number of distinguished workers in child psychiatry and in the social sciences to discuss some of the concepts involved and to submit working papers which could be presented as a followup report. These are the contents of the new publication, issued as public health paper No. 14. They are informative and interesting essays on such topics as the subtle effects of covert deprivation, cultural influences and patterns of primitive behavior as viewed in a biological context, the role of the father in deprivation especially when it leads to juvenile delinquency, and critical reviews of research considered by an expert in social theory and a psychoanalyst.

The most noteworthy contribution in this monograph is that of Mary D. Ainsworth, who here serves in a way as the unofficial spokesman for Bowlby, yet presents challenging and informative opinions of her own. As a former associate of Dr. Bowlby at the Tavistock Clinic, Dr. Ainsworth is familiar with Bowlby's changed ideas about the theories involved and his attitudes about the criticisms which have been aimed at his thesis. Furthermore, she is a psychologist who has carefully studied the vast numbers of articles which followed the 1951 publication with the aim of gleaning from them the most pertinent data which would elucidate the mechanisms involved in maternal deprivation, of clarifying the chief controversial questions remaining and of stimulating new research. It is her conclusion that the last word has still not been said about the manner in which insufficiency, discontinuity, and distortion of maternal care affects young babies and children, how long the traumatic influences are noticeably operating, and what rehabilitative powers and practices are or should be available to undo any damage which has been suffered.

The Question of Reversibility

Although Bowlby at one time was criticized as being too Freudian in his theoretical conceptualizations and his interpretations of the mechanisms of deprivation, Mary Ainsworth is more eclectic and views the effects of deprivation through the theoretical frames of reference of learning theory and of ethnology as well as psychoanalysis. Her conclusions as to the opportunities for restoration to normal development after deprivation are somewhat more hopeful than those expressed previously by many other persons. She makes nine points about how to overcome impairment which should furnish professional persons with guidelines as to reeducational and therapeutic measures.

Provence and Lipton at Yale University, in a work about to be published, agree with Ainsworth's conclusion that judgments about the reversibility of

impairments attributable to early interference with development by deprivation, separation, or distortion in parent-child interaction seem to be very much dependent upon the level of assessment. The more superficial the assessment is of the evidence of damage incurred and of its later effects, the more possibility there seems to be of reversibility. As one uses better clinical observational methods, structured examinations and intensive followup, the better the assessment and the more evidence there is of lasting damage.

Even though the effects of deprivation may be more frequently changeable and more readily reversible than was believed in 1951, there is still evidence of a distinct limitation to the readiness and the extent of improvement in cases of severe impairment of long standing. Hence there continues to be a need for caution in considering placement of children, especially the appropriate age at which they are to be separated from parents, the nature of the separation, its length and duration, and particularly the characteristics of the substitute institution, whether it be a hospital, a foundling institution, or a foster home.

Everyone seems agreed that more research is needed to further understand the conditions which make for good mothering, whether this be in the natural home or outside of it. The saying of a well-known woman of the underworld, "a house is not a home," may be aptly paraphrased, "every parental figure is not a parent." As a reminder of this, the new publication by WHO, like its predecessor on the same subject, will prove of inestimable value and interest to social scientists as well as to workers in social welfare.

[1] Bowlby, John: Maternal care and mental health. World Health Organization Technical Monograph Series, Geneva, 1951.

Guides and Reports

ON THE SEASON: a report of a public health project conducted among Negro migrant agricultural workers in Palm Beach County, Fla. Robert H. Browning and Travis J. Northcutt, Jr. Florida State Board of Health Monograph No. 2. Jacksonville. 1961. 66 pp. Limited quantity free on request from the Division of Health Education, Florida State Board of Health, Post Office Box 210, Jacksonville 1.

The second of two monographs concerned with migratory agricultural laborers, put out by the State Board of Health of Florida, this publication reviews findings of a 5-year project in Belle Glade, undertaken by a multidisciplinary public health team of the county health department, to determine the health needs of these people and to develop services to cope with them.

STUDIES OF ILLNESSES OF CHILDREN FOLLOWED FROM BIRTH TO EIGHTEEN YEARS. Isabelle Valadian, Harold C. Stuart, and Robert B. Reed. Longitudinal Studies of Child Health and Development, Harvard School of Public Health. Monographs of the Society for Research in Child Development No. 3. Child Development Publications, Purdue University, Lafayette, Ind. 1961. 125 pp. $3.25.

An analysis of patterns of illness experience of 67 boys and 67 girls, in total and separate categories, showing relative frequencies of different illnesses at successive ages and throughout total childhood—illustrated by a large number of charts and tables.

SOCIETY AND HEALTH IN THE LOWER RIO GRANDE VALLEY: based upon the findings of the Hidalgo Project on differential culture change and mental health. William Madsen. Hogg Foundation for Mental Health, The University of Texas, Austin 12. 1961. 36 pp. 20 cents.

The product of 4 years of intensive study of folk customs, social organization, medical practices and beliefs among Mexican-Americans in three communities in the lower Rio Grande Valley, this description concludes with 14 recommendations to improve relations between modern medical and welfare workers and the Mexican-Americans needing help, in the interests of more effective service.

CAREER TESTING FOR SOCIAL WORK THROUGH SUMMER WORK EXPERIENCE: a guide to local communities in organizing a program for summer experience in social work. Council on Social Work Education, 345 East 46th Street, New York 17. 1961. 48 pp. 75 cents.

Based on the experiences of summer work programs in operation for college students who are potential social work recruits, this guide advises on such aspects of the summer program as objectives, organization, assignments, seminars, field trips, and financing.

ANALYZING SOCIAL WORK PRACTICE BY FIELDS. Harriett M. Bartlett. National Association of Social Workers, 95 Madison Avenue, New York 16. 1961. 69 pp. $1.50.

The pamphlet discusses the principles and ideas underlying social work, some variations in practice in different fields, and implications of these for the social work profession.

BOOK NOTES

COTTAGE SIX: the social system of delinquent boys in residential treatment. Howard W. Polsky. Russell Sage Foundation, New York. 1962. 193 pp. $3.25.

Contours of a delinquent subculture thriving among disturbed adolescents in a residential setting—and unwittingly reinforced by staff—emerge in this sociologist's account of his 8 months' stay as a participant-observer in a cottage of the "toughest" and oldest boys in a treatment center for disturbed children.

The author, who is on the faculty of the New York School of Social Work, undertook the experience to propose ways of bringing the informal social system of the cottage, which had been blocking therapeutic efforts, into the center's treatment orbit.

Drawing on a liberal fund of experiences and recorded conversations with his 28 cottagemates, the author demonstrates the nature of the subculture—as authoritarian, distrusting, threat oriented—and the staff's accommodation to it. He also traces modes of interaction among the boys and paths of upward social mobility from "punk" or "queer" to higher status roles.

The closing chapters hammer on the theme that conforming with the cottage values hinders the boy's transition to values of the professional staff, whose goals he is expected to achieve.

To close the gap in the two sets of values, the author argues for changing the center's policy of segregating aggressive boys; and for deeper understanding by the psychotherapists of the peer group culture, its impact, and the boy's role in it. His broad proposal is for dovetailing techniques of social intervention with individual therapy.

ON ADOLESCENCE: a psychoanalytic interpretation. Peter Blos. The Free Press of Glencoe, New York. 1962. 269 pp. $5.

I? I? What am I? . . . I, hey I! What is I? . . . asks the opening passage of a fragment from a teenager's poem quoted at the beginning of this book. *I is to create*, ends the passage, and with this as a theme the author of the book traces, within the frame of psychoanalysis, the fine threads that make the fabric of adolescent personality. The author, a psychiatrist with the Bronx Municipal Hospital of New York, reviews briefly the ways personality develops during preadolescence and then goes into an intensive discussion of adolescence itself.

He focuses especially on the ego during adolescence and its achievement of a new level of psychological homeostasis brought about through an organizing principle which the author terms, "the self"; and on the interplay of environmental determinants and emotional growth factors.

Though the author for the most part does not focus on psychopathology, he concludes the work with two examples of deviant adolescent development, one illustrating "the male syndrome"——prolonged adolescence—and the other, "the female syndrome"—pseudoheterosexuality—as displayed in delinquent behavior.

THE POLICE OFFICER AND THE CHILD. Mary Holman. Charles C Thomas, Springfield, Ill. 1962. 150 pp. $5.50.

This book by a policewoman in Bakersfield, Calif., offers guidelines on crime prevention to police officers, officials, and students. Beginning on the note that although children may be small, children's cases are not "little" cases, particularly when mishandled, the author "talks shop" to her colleagues, pointing out that a crime prevention program means more than planning to "keep 'vags' on the move" or to "clean out that drive-in where the no-good kids are hanging out. . . ."

Her central theme is that the keynote of a crime prevention program should be the concept that the individual policeman's mode of conduct and attitude toward children is a vital element in their formation of positive or negative attitudes toward law enforcement.

Offered in six parts, the author's advice covers work with youth organizations; the techniques of interrogating in a broad variety of situations—including responding to the call of a belligerent parent wanting the officer to "scare" his stubborn 5-year-old into "going to the bathroom"; and meeting special problems such as dealing with the child victim of the sex offender. The author also suggests nuances of technique for enhancing police-child relations.

INSTITUTE ON JUVENILE DELINQUENCY. Southwestern Law Enforcement Institute, Southwestern Legal Foundation, Dallas, Tex., November 1961. Charles C Thomas, Springfield, Ill. 1962. 180 pp. $6.50.

The 13 papers in this book present various aspects of the problem of juvenile delinquency from the vantage points of juvenile judges, Federal consultants, educators, psychologists, attorneys, juvenile officers, and training school and camp administrators. They consider, among other subjects, the causes of delinquency, the role of the police in control, interviewing youthful offenders, processing of police referrals, and juvenile court philosophy.

EDUCATIONAL TELEVISION—THE NEXT TEN YEARS; a report and summary of major studies on the problems and potential of educational television, conducted under the auspices of the U. S. Office of Education. The Institute for Communication Research, Stanford, Calif. 1962. 375 pp. $1.

Contributed by educators and other specialists in the communication media, the contents of this volume report on four separate studies carried out by private research bodies, summarize the testimony presented before a television study panel of the Office of Education, and list guidelines and recommendations made by the panel. These favor, among other things, the organization of State and regional networks toward the ultimate creation of a "live," interconnected, educational television network. Among the subjects discussed are a projection for the next decade of television's role in education and its community job; ways to improve educational television programs; and financing, resources, and facilities.

HERE AND THERE

The Family

A strong image of the family as a source of stability during times of rapid cultural change emerged during discussions at the 5-day International Conference on the Family convened July 23 in Rabat, Morocco, under the sponsorship of the Royal Moroccan Government and the International Union of Family Organizations. Concentrating on family and youth problems that are being churned up by swift social changes in newly developing countries, some 200 delegates from family, youth, social service, and related organizations and official agencies in 38 countries—including 19 in Africa and Asia—took part in the conference's 3 work groups and in the plenary sessions.

Addresses by representatives of the African countries of Ghana, Mali, Algeria, the Republic of Central Africa, and Morocco were highlights reflecting the geographical and cultural orientation of the conferees.

The principal currents of discussion were on the evolution of family structure in countries undergoing social, economic, political, and institutional transformation; relations between parents and teachers, and family and school; the organizational structure of educational and vocational guidance facilities; preparation of young girls and women for domestic and family roles as well as for professional life.

Among other developments, these discussions revealed—

- A trend toward the setting up of ministries or departments of family affairs in national governments—since 1945, 17 countries have created such bureaus and affiliated them with the International Union of Family Organizations.
- A tendency, especially in Africa, to make a distinction between education and instruction, education being defined as aiming not only to develop the faculties but also to build up the personality into an integrated whole, fully aware of the problems of life.
- A growing awareness of the need for parent education to bridge the gap between parents who are living a traditional, tribal life and their children who have been drawn out of the tribal family by the rapid social flux; and a widely shared conviction that this gulf can be narrowed by the active partnership of parents and teachers.
- A commitment on the part of many countries to the democratic form of local organization in order to achieve desired goals.

Radioactivity

On August 1, in the Salt Lake City milkshed, after milk samples in July showed marked increases in the average concentration of radioactive iodine, the dairy industry shifted some dairy herds supplying fresh milk, from fresh pasturage to stored feed; and diverted milk from other herds to the output of butter, cheese, and other milk products, since the iodine in such products virtually loses radioactivity by the time they reach the consumer. The action was undertaken with guidance from the Salt Lake City Health Department, the Utah State Health and Agriculture Departments, and the University of Utah. Similar action was taken on August 17 in Minnesota, and was under consideration in Iowa. However, these measures were later abandoned.

The average concentration of radioactive iodine in milk in July was 580 micromicrocuries per liter in Salt Lake City, compared with an average that month of 40 micromicrocuries per liter for the 61 stations in the Public Health Service milk sampling network. Except for Laramie, Wyo., where the July average was 370 micromicrocuries, the average concentration of radioactive iodine in all other stations that month was below 100 micromicrocuries.

The procedure of placing dairy cattle on stored feed was developed from research conducted in the fall of 1961 by the Public Health Service and the U.S. Department of Agriculture. The milk industry reportedly considers this to be the least disruptive to milk production and distribution among various procedures suggested for reducing the intake of radioactive iodine from fresh fluid milk by the population.

The chief guides which had been used as a basis for shifting the herds in Utah and Minnesota were the "Radiation Protection Guides," published by the Federal Radiation Council in the *Federal Register* of September 26, 1961. However, on September 10, 1962, the Federal Radiation Council adopted a statement, later released to the press, pointing out that the Council would not have recommended such action.

According to this statement, while the guides establish "a graded series of appropriate actions related to three ranges of transient daily rates of radioactive materials by exposed population groups," they are not presented as dividing lines between safety and danger in actual radiation situations "nor are they alone intended to set a limit at which protective action should be taken."

The statement maintains that individual fallout situations require individual evaluation which "must involve a careful examination of the source and magnitude and duration of the probable exposure levels as well as the health significance of the probable exposures balanced against the total impact of health protective measures."

The Council announced its intention to prepare a report on fallout summarizing the known physical phenomena, the health implications, and the present surveillance network, and discussing the applicability of possible countermeasures.

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The University of Maryland School of Medicine is undertaking a comprehensive research program on the response of living cells to high-energy radiation. The studies, which are being financed by a $150,000 grant from the National Cancer Institute, Public Health Service, will focus on such factors as the effects of radiation on cellular nutrition, rate of growth and division, metabolism and oxygen concentration; the interrelationships between chemical agents and radiation; and the importance of the tumor bed in the development and treatment of tumors. The program is being directed by Dr. Fernando G. Bloedorn, head of the department of radiotherapy at the university hospital; it is being conducted

in the department of radiology, headed by Dr. John M. Dennis, professor of radiology.

Services in Housing

The first project of "concerted services" for families in public housing developments, sponsored by the Joint Task Force on Health, Education, and Welfare Services and Housing, was launched last summer in the Pruitt-Igoe public housing development of St. Louis. The project's goal is to demonstrate, through the combined efforts of Federal, State, and local public and voluntary agencies, how coordinated health, education, and welfare services can be applied to the needs of the 2,600 families in this low-income development—half of whom are receiving public assistance—as well as to the needs of other persons living in the neighborhood.

The 30-member task force was formed in March to identify services needed by families in such housing developments and to arrange for providing these developments with a concentration of appropriate services. (See CHILDREN, May–June 1962, page 124.)

One of the reasons St. Louis was selected last June as the scene of the first project was that the city was giving major attention to the needs of public housing residents as a result of a study made by a local committee on public housing and social services appointed by the mayor in 1960. For example, a local office of the State welfare department was already in operation within the housing development, and the local health department had set up a maternal and child health center across the street.

The local housing authority is making space available for other services, which will include an information and referral center. Other agencies planning to locate offices in or near the housing project are the Federal Bureau of Old Age, Survivors, and Disability Insurance, and the Missouri State Employment Service.

Local social, health, and education agencies have promised to give high priority to the problems of people living in the Pruitt-Igoe development and the neighborhood, with the major responsibility for individual families to be carried in each instance by a single agency charged with bringing to bear all the indicated services.

Overall policies for the project are formulated by an advisory and planning board, with appropriate functional committees. Appointed by the mayor, the board is composed of members of local coordinating bodies such as the Health and Welfare Council and the Metropolitan Youth Commission; appropriate departments of State government; and professional, service, and civic groups. A newly created Community Services Division in the St. Louis Department of Welfare is responsible for the coordination of services under the board's policies. Technical consultation is provided by the task force and the HEW regional office in Kansas City. The regional office is also working with Missouri agencies of the State government in helping to channel available resources to the area. For example, $25,000 worth of surplus machine tools have been allocated to the St. Louis school system as training aids in the vocational education program.

The availability of research resources at Washington University was another factor which led to the selection of St. Louis as the scene of the demonstration. The university has agreed to conduct research aimed at: (1) evaluating the effects of the project on the individuals served; and (2) identifying effective methods of service coordination that can be applied to other areas.

Federal Legislation

A bill authorizing a program of Federal aid for health care of the Nation's million migrant farmworkers and their dependents was signed into law in late September. The legislation authorizes the Public Health Service to make project grants for health services up to a total of $3 million a year for the next 3 years to State or local public health agencies or other nonprofit agencies and institutions in States through which migratory farmworkers stream each year to harvest crops. The funds are to be used to help finance the cost of establishing and operating health clinics for such workers and their families, and for otherwise improving health services for and health conditions among such families.

. . .

In October the 87th Congress amended the Public Health Act to authorize the establishment by the Public Health Service of an Institute of Child Health and Human Development. The Institute's functions are to conduct and support "research and training relating to maternal health, child health, and human development, including research and training in the special health problems and requirements of mothers and children and in the basic sciences relating to the processes of human growth and development, including prenatal development."

To avoid overlapping of effort, the Public Health Service and the Children's Bureau have developed a working agreement. The Children's Bureau will concentrate on improving the development, management, and effectiveness of maternal, child health, and crippled children's services, while the Institute's research programs are to be directed toward the development of new knowledge relating to health problems and requirements of children and the phenomena of human growth and development.

For Health

By the end of last summer, 44 community health studies and demonstrations were underway in various parts of the country, with the help of grants from the Public Health Service, authorized under the Community Health Services and Facilities Act of 1961. Purpose of the grants is to develop new or improved methods of providing health and medical services. Totaling $2¼ million, the grants were made to public and nonprofit organizations, including State and local health departments, hospitals, universities, and professional organizations.

Among the projects are:

- Two demonstrations—in Dade County, Miami, Fla., and Monroe County, Rochester, N.Y.—on the coordination of public and voluntary health organizations in a communitywide program of comprehensive health care.
- An experiment at the University of Southern California, with the use of electronic computers in storing and retrieving information on all patients known to hospitals, nursing homes, and health and welfare agencies in Los Angeles.
- The establishment by the Rip Van Winkle Foundation, Hudson, N.Y., of nonprofit supplementary services to patients of a group practice clinic providing both medical and dental services on a prepaid plan. The added services

will include home nursing, physical therapy, nutrition counseling, social casework, dental hygiene, and medical specialty consultation.

• A 3-year study to be undertaken by the California Medical Education & Research Foundation to develop methods of assessing the quality of medical care in the practice of individual physicians.

• A long-range study by the Group Health Association of America to develop basic data on the use of specific health services in a large population group according to age, sex, socioeconomic status of the users, and other factors.

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A conference on Standardization and Maintenance of Nomenclature and Comparable Clinical Statistics in Obstetrics, Gynecology, and Pediatric Care of the Newborn was held in the Children's Bureau on September 27, 1962. The meeting was attended by representatives from the American College of Obstetricians and Gynecologists, the American Hospital Association, and from university departments of obstetrics and gynecology, pediatrics, and of maternal and child health, as well as interested offices in the Department of Health, Education, and Welfare, and the Medical Corps, U.S. Navy.

It was decided that leadership should be provided by the American College of Obstetricians and Gynecologists in formulating and carrying out a program for standardizing terms in the medical specialties especially concerned in the areas of maternity and infancy. The American Academy of Pediatrics and other interested professional groups will be asked to collaborate. The work of the program will be coordinated with the current medical terminology project of the American Medical Association.

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The Community Service Society of New York City has recently released a report of a pilot demonstration of family-centered public health nursing services in the homes of maternity patients in an underprivileged area of the city. Completed in June 1961, the project was begun 2½ years earlier, with the collaboration of the city health and hospital departments and the New York Medical College-Metropolitan Hospital Health Center. The purpose was to assess the feasibility and effectiveness of the service offered as a supplement to the usual municipal hospital services and to develop criteria for selecting families most able to benefit from it.

Among patients receiving prenatal care at a municipal hospital, 225 were selected at random and divided into a control group and a service group. Of the latter, 80 patients received the full service for themselves and families during the maternity cycle and at least 4 months after confinement. Provided by five nurses, this service entailed mainly individualized health guidance in meeting immediate problems, from dental caries to diabetes, and in acquiring self-direction in health matters.

Substantial gains were noted in many of the served patients' physical health, nutritional practices, and physical and psychological readiness for delivery. Found most able to benefit from the service were patients with the most concern about the family's health needs and apparent capacity for productive interpersonal relationships.

Entitled "Serving the Maternity Patient Through Family-Centered Public Health Nursing," the report is available on request (until supplies are depleted) from the society, 105 East 22 Street, New York 10.

Dental Care

The likelihood that specific oral manifestations of retardation, such as drooling and tooth grinding may, in some instances, be due to dental pathology rather than retardation, is pointed up in preliminary findings of a pilot study involving dental work on 47 child patients at the Institute for Retarded Children of the Shield of David, New York. Reported at the annual conference of the American Association on Mental Deficiency in May, the study covered children with severe dental problems including abscesses, pulp exposure, and periodontal diseases, treatment of which brought these results: of the children reported as drooling, 50 percent stopped; of those reported as grinding their teeth, 66.6 percent stopped; among those reported as not chewing, 63.6 percent began to chew; of the poor eaters, 38.09 changed to good eaters; and of those who habitually placed miscellaneous objects in their mouths, 35 percent stopped. Among the children who awakened crying during the night, 53.9 percent began to sleep through. These results represent the correlated answers to questionnaires from parents, teachers, and the school psychologist during the week after treatment.

Explaining how each of the oral manifestations can be caused by dental pathology, the report points out, among other details, that since the process of swallowing calls for the meeting of the lower and upper teeth and that such contact is painful in the case of an abscessed tooth, when such a condition exists in a retarded child—many of whom find difficulty in making known their complaints—they tend to avoid swallowing and to keep their teeth apart, and thus drool; and also that it is common for a person to grind on a tooth around which gingival inflammation exists.

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A grant of $152,758 was recently awarded by the National Institute of Dental Research, Public Health Service, to the Columbia University School of Dental and Oral Surgery for a 3-year graduate program of training dentists for careers in research and teaching in the field of dentistry for handicapped children, especially those who because of neuromuscular conditions cannot sit still in the dental chair.

The Columbia program in treating handicapped children, dating back to 1951, stems from the efforts among parents of cerebral palsied children in the 1940's to obtain dental care for their children and from the efforts, in turn, of a group of interested dentists to gain the cooperation of a dental school in developing the program. Since the program was initiated, about 1,200 handicapped children, including about 1,000 with cerebral palsy, have been treated at the school's clinic, which is one of four such clinics sponsored by the New York City United Cerebral Palsy organization. Its fellowship program has been supported by the United Cerebral Palsy Research Educational Foundation.

Child Welfare

"New Goals and Directions in Child Welfare—1962–75" was the theme of a regional child welfare meeting held by the Children's Bureau in Charlottesville, Va., July 9–11, 1962. Representatives from public welfare and public health agencies in six States in region III participated in the meeting.

The group gave special attention to the need for more effective recruitment methods for child welfare staff; for better understanding of public child welfare in schools of social work; and for more fieldwork placements in public child welfare programs for students attending graduate schools of social work. Licensing and consultation, especially in the area of day care, were also the subjects of considerable discussion. Special attention was given to the function and responsibility of public welfare, education, and health agencies in establishing standards for licensing and for providing consultation to day-care operators and boards and for interpreting the meaning and importance of licensing to the public.

From data provided through questionnaires sent to the State welfare departments in preparation for the meeting, the Bureau's regional office is preparing a comprehensive report on licensing in the eight jurisdictions comprising Region III—Kentucky, Maryland, North Carolina, Virginia, West Virginia, the District of Columbia, Puerto Rico, and the Virgin Islands. The report will provide information on State licensing laws, standards, agencies responsible for licensing, numbers of licensed child-caring agencies and day-care centers, types of licenses granted, types of disciplines involved in the development of standards, implementation of licensing standards, use of advisory committees, educational programs for licensing staff and for the staff of the facilities to be licensed, and other details.

The purpose of the report is to help States and the Children's Bureau in determining areas where improvement in licensing laws is indicated, where strengthening of licensing staff is needed, and where more effective coordination is needed between welfare, health, and education authorities in developing adequate standards for day-care services, as well as for other types of child-caring facilities.

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As one response to an expressed interest of the Committee on Appropriations of the House of Representatives in increased use of Federal funds to strengthen programs for young unmarried mothers, the Children's Bureau has recently assembled facts on child welfare services relating to illegitimacy, needs not being met, and plans for improving such services. Information was obtained through questionnaire responses from the departments of public welfare of 49 States, the District of Columbia, Puerto Rico, and the Virgin Islands, as well as from other sources of statistical data.

The findings show that in every State some service is provided to unmarried mothers by public child welfare agencies, though amount and type of service vary widely. The most frequent types of service available are casework service to help unmarried mothers plan for themselves and their babies, and adoption services. Foster family care, especially for the baby, is nearly as prevalent. Maternity home care and medical care for unmarried mothers are purchased by public child welfare agencies from maternity homes, hospitals, or physicians in about one-half of the States, and in some counties of a number of other States.

Preliminary data obtained from a study of the characteristics of all children receiving child welfare services show that one-half of the unmarried mothers being served by public child welfare agencies on a given day in 1961 were living with parents or relatives and 16 percent in independent living arrangements, while one-fourth were in foster family homes or maternity homes. Four-fifths of them were under 21 years of age. Three-fourths were white. Two-thirds were from families not receiving public assistance.

Data from other Children's Bureau reports show that voluntary child welfare agencies (not including maternity homes) serve twice as many unmarried mothers in a year as public child welfare agencies. All maternity homes are under voluntary auspices.

Comparison of service figures with available figures on all births out of wedlock indicate that each year about one mother in six who bears a child out of wedlock is served by either a public child welfare or a voluntary child welfare agency.

A full report on the data assembled will be published by the Bureau in the near future.

Law and Social Work

A new national body to enhance understanding and active cooperation between lawyers and social workers, the National Conference of Lawyers and Social Workers, has recently been established by the American Bar Association and the National Association of Social Workers. Composed of eight members from each of these professions, the new group met for the first time on May 27 to plan its activities and procedures.

The purposes of the organization are: to draft principles outlining legitimate activities of social workers and lawyers in areas of vital interest to both, such as juvenile delinquency or adoption; to delineate and give advice on areas in family law within the competence of lawyers and handle complaints about infringement of legal practice; to divide activities between the two groups relating to the development of legislation and suggest proper areas for mutual consultation; to distribute information on research projects; and to undertake activities to promote better understanding between the two professions.

At the May meeting, the group decided to begin developing principles in regard to adoptions and the relationships between lawyers and social workers attached to courts. Proposals deferred for future consideration include the development of local legal-social work forums, the issuance of a statement on the use of paid legal consultation by social agencies to increase understanding of legal implications in case situations, and joint teaching or joint research programs. The next meeting is scheduled for early 1963.

The new body is a result of recommendations made by the Family Law Section of the American Bar Association and the Committee on Lawyer-Family Agency Cooperation of the American Bar Association. Cochairmen are Sol Morton Isaac of Columbus, Ohio, representing the American Bar Association, and Jacob T. Zukerman of New York, representing the National Association of Social Workers.

School Dropouts

During August, the Urban League of Greater New York launched a "success center" for high school dropouts which combines the services of several agencies to enhance the job futures of these youths. The center, located in Harlem, is scheduled to run for a year on a $75,000 grant from the New York State Division for Youth, made through the New York City Youth Board.

The primary function is to encourage

school dropouts to return to school for some kind of training. Those unable to resume formal schooling are stimulated to undertake appropriate training outside of school.

The project employs a special staff of administrative social caseworker, psychologist, vocational guidance specialist, and work supervisor, providing diagnosis and treatment of the personal, social, family, psychological, and vocational problems that probably underlay withdrawal from school. In addition, a youth employment service counselor has been detailed to the center from the New York State Employment Service.

The Harlem program is one of eight youth and work training programs financed by the State division for youth. The Police Athletic League, the YMCA, Vocational Advisory Service, and East Harlem Y.E.S., Inc., also operate programs under subcontract with the New York City Youth Board, and in Buffalo, Rochester, and Syracuse similar programs are operated directly by local youth boards.

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In St. Louis, Mo., a total of 2,579 youths dropped out of school during the 1960–61 school year, according to a study recently completed in the city's public school system by Dr. George Mowrer. Dropping out was attributed principally to "general lack of interest" (688); "reasons unknown" (533); "entrance into the armed services or employment" (485); and "marriage or pregnancy" (291). Of the total group, 26.4 percent withdrew in the 9th grade; 30.5 percent in the 10th; 23.5 percent in the 11th; 15.8 percent in the 12th; and 3.4 percent in other grades.

Adoption

A 3-year study of adoption in New York State recently completed by the New York State Committee on Adoption found that 21 percent of the children under the care of 96 foster care agencies in the upstate counties in 1959 were "presumptively adoptable"—19 percent of the white and 27 percent of the nonwhite. Among these, 52 percent of the white children and 82 percent of the nonwhite children were categorized by the agencies as "hard-to-place." Among the white hard-to-place children, age or "legal aspects" were named as the chief barriers to adoption for 69 percent, and physical or emotional handicaps for 19 percent; but race was the chief barrier cited for three-fourths of the nonwhite hard-to-place children.

Similar deterrents to adoption were reported by 77 adoption agencies, both upstate and in New York City, which had 2,648 children under study for adoption, about 62 percent of whom were considered hard to place—47 percent of the white children and 92 percent of the nonwhite children. Again the only barrier to adoption named for three-fourths of the nonwhite hard-to-place children was race.

The study committee proposed, among other recommendations, that—

- A child's adoptability be determined and placement made at the earliest possible time.
- Ways be explored for finding more adoptive homes for the hard to place, including increased spread of information, use of adoption clearance services, and experimentation with short-term financial aid to adoptive parents.
- Adoption practices be flexible enough to be adapted to the changing needs of children.
- Full use be made of the 1959 amendment to the State's adoption laws that created a new legal category of the "permanently neglected child."

The proposals also urged increasing the degree and quality of teamwork among the professions in the adoption process.

The study was sponsored by the State Charities Aid Association and the New York State Association of Councils and Chests, which have published the report under the title, "Facts to Build On; a Study of Adoption in New York State."

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A new Kentucky law on adoption, designed to give more protection to children and adopting parents and to end black-market traffic in babies, became effective June 14. The law contains a requirement that a child for which adoption is sought must have been placed for adoption by a licensed child-placing institution or agency or by the department of child welfare or with written approval of the commissioner of child welfare. Penalties for violations include fines not less than $500 nor more than $2,000 or jail terms up to 6 months, or both. The law provides for exceptions in instances of adoption by close relatives or of children received from an approved agency in another State, with the commissioner's written consent.

Accident Statistics

A study of injuries involving toys and playthings sustained by children in Florida was recently conducted by the Florida Pediatrics Society, the Florida chapter of the American Academy of Pediatrics, and the Florida State Board of Health, with the sponsorship of the Toy Safety Committee of the National Safety Council. Pediatricians, general practitioners, and staff of emergency wards provided information on 748 such injuries treated during the months of June 1960, October 1960, and February 1961, revealing that nearly three-fourths of the accidents occurred to children under 6 years of age. Bicycles and tricycles were the playthings most commonly responsible in about 22 percent of all the accidents studied.

According to information obtained from parents of 54 of the children, there was lack of supervision at the time of the accident in 24 cases; in 10, the children did not have proper knowledge regarding the correct use of the playthings; in 14, the playthings were not used in a proper manner; and in 18, the injury occurred through the actions of other individuals.

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Among the estimated 800,000 or more cases of accidental poisoning that occur yearly in the United States, the U.S. National Health Survey reports that almost 40 percent are in children under 5 years of age. The National Clearinghouse for Poison Control Centers, Public Health Service, has received reports for 1960 from 213 poison control centers of about 29,000 accidental ingestions by children in this age group, internal medicines having been involved in the largest number of cases. Thirty-three of these cases in 1960 resulted in death. In 1959, accidental poisoning from solid and liquid substances by children under 5 claimed almost as many lives (456) as did septicemia and pyemia (560), and ranked above meningococcal infections (441) and dysentery (223).

The Clearinghouse lists 490 poison control centers in 48 States and the District of Columbia, Canal Zone, Virgin Islands, and Guam. Of these, 442 give treatment as well as serve as information centers.

READERS' EXCHANGE

SORENSON: ***Vs. youth participation***

Roy Sorenson's article in the July–August 1962 issue of CHILDREN ["Youth's Need for Challenge and Place in Society"] is on firm ground in pointing out certain focal problems of youth such as the problem of identity, of self-esteem, of alienation, of privatism, and of lack of commitment to adult values and goals. I am also impressed by Mr. Sorenson's challenges to adults to help meet youth's need for (1) competence in self-fulfilling activity, (2) understanding, (3) a truer public image, (4) work and responsibility, (5) recognition of excellence in areas other than athletics, and (6) commitment to a better future for mankind.

Where I lose contact with Mr. Sorenson is in his discussion of the youth subculture as if this were, merely because of its existence, a desirable expression of youth. I cannot join those dedicated to recognizing youth as a separate category of the human species, entitled to set up shop as a culture or civilization all its own.

Youth exists by virtue of the labor of others; it has not produced anything and does not, in the main, have the education or experience to make worthwhile judgments on the larger or smaller issues of our time. In short, I am opposed to a child-oriented or a youth-oriented society.

What I am interested in is that through an effective family system for child rearing and through a much more capable system of public education than we now have, plus better religious training and better private agencies, every child will be exposed to and in some significant measure absorb the best values of our Western civilization and become an effectively functioning individual within the framework of the adult society. I regard youth as a period of adaptation and training to occupy ultimately an intelligible place in the adult world.

I would develop every youngster with a good critical sense in reexamining much of the tenets dominating our thinking, but willing to conform to the existing framework until he can find something at a more mature age that he is convinced is better. I am not interested in making a cult out of adolescence.

I would not have any youths participating in the 1970 White House Conference as they did in the 1960 conference. While I would favor any statewide or national gathering of youths with the same focus, I think it is a little presumptuous for youth to undertake to dictate or to advise elders concerning the management of the family and of organized society when they are the recipients and not the determinants of whatever adult society has to offer them. It seems absurd to have a gathering of adults of all ages and professions, including many of distinguished competence in the human engineering professions, and allow them to be outtalked and shoved aside by a claque of assertive and ambitious youngsters.

Thus, I differ with Mr. Sorenson in some of his basic assumptions and would revert in some degree to the old rule that "children are to be seen and not heard," and are to apply themeslves to such measures of thought and action as will fit them to become part of the adult world in its existing culture. That culture is far from perfect, but I am not prepared to turn it over to the adolescents for remaking. I don't mind them trying later on when they are a little older.

Chauncey M. Depuy
President Judge, 39th Judicial District of Pennsylvania, Franklin County, Chambersburg, Pa.

Author's reply

Judge Depuy's letter warrants attention because it reflects rather widespread adult views about youth:

1. The *say it isn't so* attitude that would ignore the phenomenon of modern youth and belittle its manifestations.

The fact is that adolescence in today's urban industrial society, because of the unprecedented length and relatively recent detachment from responsibility, bears striking differences from adolescence in mankind's long past. Twenty million young people in America suspended between childhood and adulthood for the better part of 10 years is a sizable segment of the human species and deserves a category, as much as do infants, children, adults, and the aged.

Adults cannot escape their obligation to understand the varieties of teenage culture and why they arise by protesting that young people are not "entitled to set up shop as a culture or civilization of their own." Subcultures, whether racial, economic, professional, suburban, rural, urban, regional, or teenage, share in common the fact that they arise from external pressures as well as internal forces. Teenage subcultures are spawned by urban, industrial society all over the world. To recognize that the lot of teenagers in the affluent society has resulted in the varied coping mechanisms (some useful, some destructive) is not to make a "cult of adolescence," nor is it to imply that youth is allowed special privilege.

2. The attitude which says, *let's keep them in their place.*

The judge's words indicate that he is representative of that large segment of adult society which is not about, as he puts it, ". . . to be outtalked and shoved aside by a claque of assertive and ambitious youngsters."

Assertive youngsters? We should begin to worry when they have nothing to assert. Ambitious youngsters? Where will we be tomorrow if they are not ambitious? Youth-oriented society? A slight shift youthward will scarcely rock the boat of adult-oriented society. Young people who exist by virtue of the labor of others? Whose fault is it that our grown boys cannot find a man's work to do? Why should we adults clutch with so much grimness our monopoly on responsibility and resist finding appropriate ways of sharing some of it with youth?

Adolescents (who are not children) will not grow into the kind of adults we want by keeping them in their places, but by having more opportunities to function along with adults in the real tasks of community and nation. If we move over and make room for youth with good humor and grace, we won't have to worry so much about being "shoved aside."

3. The attitude which says *improve*

the historic child-rearing institutions and let's not worry about societal forces.

By all means improve the child-rearing institutions. They need it. And they will be improved and their effectiveness multiplied when they take into account the societal forces which have made the world troubling for older adolescents and which have crucial impact upon our institutions as well. Home, school, church, and agency need broader youth-in-society understanding and program if they are to do their job in these times.

Relying on the older, individual-centered methods still honored by the historic guardians of the young will not provide challenge, responsibility, and larger place for older youth. Adult institutions must blend their older functions with larger efforts to understand and to upgrade youth's opportunities for real involvement with adults in the tasks of the times.

Roy Sorenson,
General Secretary, YMCA of San Francisco, Calif.

HORNECKER: ***Credit to the team***

In her article in the July–August 1962 issue of CHILDREN ["Adoption Opportunities for the Handicapped"] Alice Hornecker has most adequately pleaded for a different, more positive approach to the adoption of handicapped children. The achievement of this goal would be an advance of great importance and of lasting benefit to society.

There is, however, a danger in her presentation of which we should be aware, especially as we work in conjunction with physicians or other professional auxiliary to medicine. Without its being explicitly stated, the idea is conveyed that most of the marked improvements in the children discussed occurred because of the very adequate foster home or adoptive placements in a manner primarily independent of any other help the children received, rather than in conjunction with this other help. This is especially true in the case of Jimmy whose IQ jumped from 36 to low normal in 6 months, and in the case of Mack who was born without legs.

For both boys many services were rendered in addition to the tender loving care given by foster parents, and these services contributed much to their rehabilitation. Certainly no experienced social worker would discount the benefits for such children of an adequate home and devoted parents—natural, foster, or adoptive—but I feel we must also guard against an unreal assumption that this is the whole answer. This assumption need not be conscious. Indeed, it is more insidious when it is not conscious.

In all work with handicapped children, we must constantly remember that it is the team effort of many interested persons and not social work alone which is responsible for improvement. Without other services, the social worker would be in an impossible position in trying alone to effect changes in handicapped children.

A. W. Lockner
Supervisor, Medical Services, Social Service Department, the Montreal Children's Hospital, Montreal, Canada

BECK: ***Rebuttal***

The May–June 1962 issue of CHILDREN [p. 102] contained an excerpt from Bertram Beck's comments at the 1961 forum of the National Conference on Social Welfare entitled, "The Myth of Prevention." The gist of the excerpt is that prevention is a concept suitable to public health but not to social welfare "where it is wholly inapplicable." In his argument, Mr. Beck makes essentially three points:

1. *The nature of health and welfare problems.* Mr. Beck argues that the nature of social welfare problems is fundamentally different from those of public health: Welfare problems, such as juvenile delinquency, are multicausal phenomena, extremely complex in nature and the result of complex chronic disorders. In contrast, public health problems, such as smallpox, are relatively simple phenomena with clearly identifiable "etiologic agents."

2. *The methods of intervention and control in health and welfare problems.* On the foregoing basis, Mr. Beck asserts that social welfare problems require different methods of control and intervention. Immunization, a preventive method, is feasible for public health but cannot be used for welfare problems such as juvenile delinquency.

3. *The populations involved in health and welfare problems.* Mr. Beck also argues that the segments of the population involved in health and welfare problems are dissimilar: Welfare problems are derived largely from the lower socioeconomic segment of the population, the "hard to reach." Public health problems, such as smallpox, in contrast, affect all segments of the population. While it is appropriate, therefore, in dealing with smallpox to pay as much attention to the healthy "easy-to-reach" middle and upper classes of the population, this is not true for juvenile delinquency, which is largely confined to lower socioeconomic levels. Intervention and treatment of the "easy-to-reach" middle class group, he argues, will have little or no effect on delinquency rates because juvenile delinquency is not essentially a middle-class problem.

I shall take these points up separately in the following rebuttal:

1. *Public health interest is not confined to acute infectious disorders,* such as smallpox. In fact, public health is increasingly concerned with the complex, chronic, somatic problems such as cancer, arthritis, and heart disease, the nature of which is not unlike the complex, chronic problems in social welfare. Moreover, social welfare, as the study of the literature will reveal, is developing an increasing recognition and concern for acute emotional disorders and crises, comparable in many ways to acute infectious disorders such as smallpox.

During World War II and the Korean action, some thought and experimentation was devoted to the possibility of "immunizing" people against the effects of certain emotional hazards such as bombing raids on the civilian population. The etiology and epidemiology of acute emotional disorders, in many but not all ways, parallels the acute somatic disorders. In fact, we are coming to see that the natures of the total range of problems of public health and of social welfare are more alike than different.

2. *The approach to welfare and health problems is therefore not fundamentally different* but quite comparable in relation to the types of problems of concern—acute or chronic. The problems of juvenile delinquency and cancer, for example, are comparable in the complexity of etiology and in methods of study and control. A similar comparison can be made between the etiology and treatment of smallpox (health

problem) and bereavement (emotional problem).

3. *The segments of population of concern for welfare problems are also comparable to those of public health.* While juvenile delinquency is largely a lower socioeconomic class problem, so are tuberculosis and the venereal diseases today. While smallpox affects all segments of the population, so do bereavement and problems that arise from early separation experiences of children, or from the diagnosis of chronic illness in parents or children.

In brief, the implied differences between public health and welfare problems are not so great as they appear.

David M. Kaplan
Associate in Social Work, School of Public Health, Harvard University

Author's reply

In response to Dr. Kaplan's three points, I would say:

1. The social work profession has much to learn from and much to contribute to the effort to maintain health and combat disease. However, certain public health prevention concepts which have been defined in respect to prevention of clearly defined disease entities can be misleading when used in respect to welfare problems.

There is a significant difference between cancer and delinquency. The definition of cancer is relatively clear. Who knows what delinquency is? As public health organizations become more interested in prevention of "emotional maladjustment" and the like, they will run into the problem with which those concerned with welfare problems are familiar; namely, the question of accountability and responsibility. One can more readily be accountable and responsible for program consequences when the target of prevention is clear.

2. Most prevention in the social welfare field involves intervention after the onset of a problem. The field has no preventive agent comparable to vaccination. Cause and effect are more obscure than in certain public health efforts. When the social work profession acts as though it had specific preventatives for welfare problems, it may fail to roll up its sleeves and work with persons who have "caught" the behavior that is supposed to be prevented. The field of public health faces the same danger as it moves into the mental health arena.

3. Surely certain diseases like certain behavior defined as "problem behavior" have higher incidence among people of the lower classes. Public health officials tend to take this into account in planning programs because where the evidence is clear and the targets of prevention sharply defined the issues cannot easily be sidestepped. When, however, a problem must be dealt with which has as many causes and manifestations as delinquency, there are dangers in approaching it as a simple entity. Thus one might define delinquency in terms of psychological maladaptation and then slip into the error of giving all clinical services for families and children the label of delinquency prevention, regardless of the likelihood of the children served ever becoming truly delinquent.

Bertram M. Beck
Associate Executive Director, National Association of Social Workers, New York

Films on Child Life

Films listed here have been reviewed by staff members of the Children's Bureau. The listing does not constitute endorsement of a film, but indicates that its contents have merit. Charges for rental or purchase, not given because they change, may be obtained from distributors.

HOSPITAL MATERNITY CARE: FAMILY-CENTERED. 28 minutes; sound; black and white; loan.

Depicts an experiment in maternity care being conducted at St. Mary's Hospital, Evansville, Ind., to point out the needs of the individual family unit and the therapeutic roles of the father in a relaxed, home-like environment during the hospital stay; to depict how physicians and other professionals in the hospital may assist in establishing the supportive relationship needed by the family unit, and to demonstrate how regular measures regarding safety and care of both mother and infant can still be maintained in a family-centered hospital environment.

Audience: Medical, nursing, and related audiences in the health field.

Produced by: Dynamic Films, Inc.
Distributed by: Mead Johnson Laboratories, Evansville 21, Ind.

DEBBIE. 27½ minutes; sound; black and white; purchase or rent.

A documentary film about neglected and deprived children who can no longer live in their own homes and the efforts made by a child welfare agency to interpret the needs and problems of these children. Its main character is Debbie, an emotionally disturbed teenage girl who is helped and rehabilitated by such an agency.

Audience: Specialized organizations and individuals interested in the welfare of children, schools of social work and nursing; led by experienced, professional caseworkers.

Produced by: Victor Weingarten and Julius Tannenbaum.

Distributed by: Health & Welfare Materials Center, 10 East 44th Street, New York 17.

THE CHILDREN'S BUREAU—ITS FIRST FIFTY YEARS—1912–1962; filmstrip with tape recording. 1 hour; black and white; 35 mm.; loan.

Documents the historic events and activities during the 50 years of the Children's Bureau. The filmstrip was presented at the 50th anniversary celebration on April 9, 1962, with the tape recorded script narrated by Ben Grauer of the National Broadcasting Company.

Audience: Official or voluntary agencies and professional and civic groups concerned with children.

Produced by: The Children's Bureau.

Distributed (on free loan) by: Children's Bureau, Social Security Administration, Department of Health, Education, and Welfare, Washington 25, D.C.

SOME U.S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

Publications for which prices are quoted are for sale by the Superintendent of Documents, U.S. Government Printing Office, Washington 25, D.C. Orders should be accompanied by payment. Twenty-five percent discount on quantities of 100 or more.

NURSES AND OTHER HOSPITAL PERSONNEL: their earnings and employment conditions. Department of Labor, Women's Bureau. Pamphlet Six. Reprinted 1961 with supplement. 41 pp. 25 cents.

A reprint of a pamphlet issued in 1958 summarizing salary and employment data collected for nurses and other hospital personnel by the Department of Labor's Bureau of Labor Statistics, including a supplement presenting statistics collected in mid-1960.

COMMUNITY PLANNING AND ACTION FOR CHILDREN AND YOUTH: how to do it. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau, Region VII, 1114 Commerce Street, Dallas 2. 1962. 42 pp. Free on request from the Bureau's regional office or from the executive secretary of the Interdepartmental Committee on Children and Youth, Room 4310, 330 Independence Avenue SW., Washington 25, D.C.

The proceedings of the regional workshop held in Oklahoma City, April 9–11, 1961, in followup of the White House Conference on Children and Youth of 1960, by Federal agencies, voluntary organizations, and State committees on children and youth in New Mexico, Oklahoma, Arkansas, Texas, and Louisiana.

THE NURSE IN HOME TRAINING PROGRAMS FOR THE RETARDED CHILD. Laura Dittmann. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. 1961. 10 pp. Free on request from the Bureau.

For public health nurses providing services to families with retarded children, in special diagnostic or clinical teams or as part of a general caseload, the publication offers guidelines for helping parents teach the young child how to take care of himself and get along with others.

A DEMONSTRATION PROJECT UTILIZING CHILD DEVELOPMENT AS THE FOCUS FOR COMMUNITY INTERACTION WITH A LOCAL HEALTH DEPARTMENT. The Child Development Clinic of Children's Hospital of Los Angeles, Calif., and the California Bureau of Maternal and Child Health, State Department of Health. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. 1962. 22 pp. Single copies available from the Bureau without charge.

A report on the program and progress of a traveling clinic initiated in 1959 to service southern California counties, through local health departments, by demonstrating the multidisciplinary team approach in providing diagnostic and counseling services to the mentally retarded child and his family, planning inservice training programs for professional personnel from local health departments, schools, and social agencies, and organizing community resources for better services to the mentally retarded child and his family.

CLINICAL PROGRAMS FOR MENTALLY RETARDED CHILDREN. Rudolph P. Hormuth. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. 1962. 33 pp. Single copies available from the Bureau without charge.

Listing by States 99 special clinical facilities for mentally retarded children, this publication is the fourth such compilation made by the Children's Bureau.

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